

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9 Film G262 5/6/60 iwk

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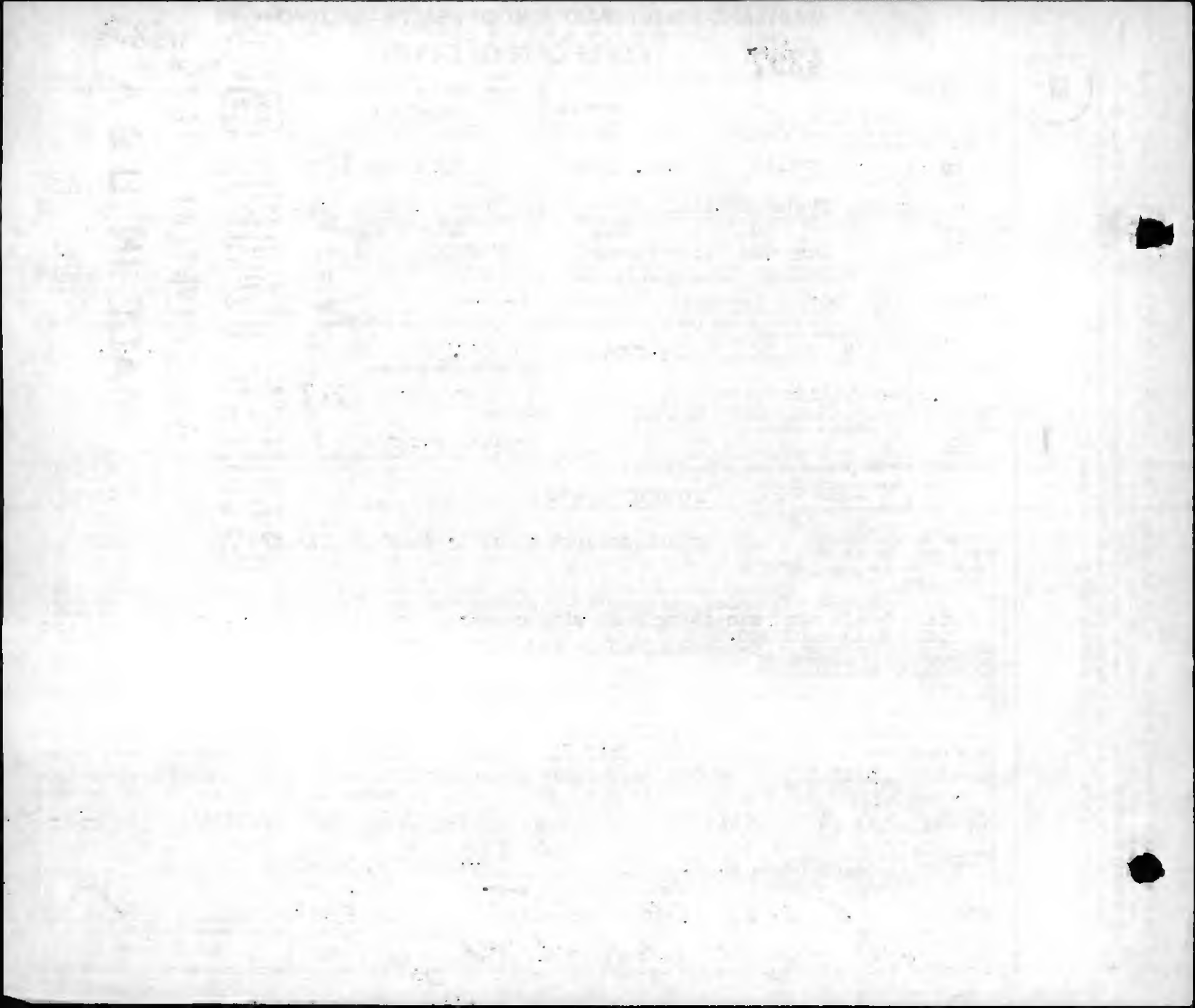
## CERTIFICATE OF DEATH

64338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN lb <b>9mog. 6days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lucretia Viola (Brown)</b> Middle <b>ASPLEMYER</b> Last <b>ASPLEMYER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-17-85 1886</b>	9. AGE (In years last birthday) <b>74 1/2</b> yrs.	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles William Brown</b>				14. MOTHER'S MAIDEN NAME <b>Mary Viola UZZ</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Informant</b> Address <b>Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) <b>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>  <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield State Hospital</b>	
20f. (City or town) <b>Sykesville, Md.</b>				(County) (State)			
21. I certify that I attended the deceased from <b>July 22, 1959</b> , to <b>April 28, 1960</b> , that I last saw the deceased alive on <b>April 28, 1960</b> , and that death occurred at <b>9:50 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ilse Kamm</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Ilse Kamm, M. D.</b>				DATE SIGNED <b>4-29-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-2-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>		22d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Haight</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haight</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltoe City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>36yrs. 1mo. 24days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>24 N. High St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Katie</b> Middle <b>Birnbaum</b> Last <b>Birnbaum</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1911</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Ida Birnbaum</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital, Sykesville, Md. Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia due to aspiration of foreign substance.</b> <b>921.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental deficiency.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b> <b>Patient aspirated a large piece of meat which was followed by pneumonia, with all the associated toxic symptoms</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>Unknown</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 20, 1954</b> to <b>April 10, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 9, 1960</b> , and that death occurred at <b>5:30A</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edmund Lusthaus</b>		22b. DATE SIGNED <b>4/11/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMAINS (Type) <b>Burial</b>		23b. DATE THEREOF <b>April 11/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oheb Shalom</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sol. Levinson &amp; Bros. Inc.- 6010 Reisterstown Rd.</b>		25a. REC'D BY REGISTRAR <b>APR 14 1960</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural, Westminster Rt. #1</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll County Home</b>			d. STREET ADDRESS <b>Silver Run</b> <b>Westminster, Md. R. D. 1</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Alvin</b> Middle <b>A.</b> Last <b>Boose</b>			4. DATE OF DEATH Month <b>4/20/60</b> Day <b>19</b> Year <b>19</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/1878</b>		9. AGE (In years last birthday) <b>82</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Canning Factory Employee, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canning Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Solomon Boose</b>			14. MOTHER'S MAIDEN NAME <b>Savannah Koontz</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-8705</b>		17. INFORMANT Address <b>Oscar F. Wentz, Manchester, Md. R. D. 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO (b) <b>Arteriosclerosis General</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arthritis Chronic</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Short Time</b> <b>Several</b> <b>Yrs</b> <b>13 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>March 7, 1960</b> , to <b>April 20, 1960</b> , that I last saw the deceased alive on <b>April 19, 1960</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>W. L. Speiches</b>			ADDRESS (Street, city or town, state) <b>Westminster Md</b> DATE SIGNED <b>4/20/60</b>		
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/22/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>		24a. REC'D BY REGISTRAR <b>APR 22 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>			ADDRESS <b>Littlestown, Pa.</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>William A. Jones</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 15 1880</i></p>		<p>4. Date of death: <i>Jan 20 1940</i></p>	
<p>5. Place of birth: <i>St. Louis, Mo.</i></p>		<p>6. Place of death: <i>St. Louis, Mo.</i></p>	
<p>7. Cause of death: <i>Heart failure</i></p>		<p>8. Immediate cause: <i>Myocardial infarction</i></p>	
<p>9. Duration of illness: <i>2 weeks</i></p>		<p>10. Period of incapacity: <i>1 week</i></p>	
<p>11. Name of physician: <i>Dr. J. H. Smith</i></p>		<p>12. Name of funeral home: <i>None</i></p>	
<p>13. Name of informant: <i>John A. Jones</i></p>		<p>14. Address of informant: <i>1234 Main St.</i></p>	
<p>15. Signature of informant: <i>[Signature]</i></p>		<p>16. Signature of physician: <i>[Signature]</i></p>	

*William A. Jones*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4399 CERTIFICATE OF DEATH 64341

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-- Westminster</b>				c. LENGTH OF STAY IN 1b <b>46 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 6</b>				d. STREET ADDRESS <b>R.D.# 6</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>CARRIE LEATHERWOOD BUCKINGHAM</b>				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 12, 1884</b>	
9. AGE (In years lost birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Owen Leatherwood</b>				14. MOTHER'S MAIDEN NAME <b>Sarah A. Nye</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mr. Willie F. Buckingham, Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Renal Disease</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis &amp; Obesity</b> INTERVAL BETWEEN ONSET AND DEATH <b>Several months</b> <b>Several yrs</b> <b>6-8 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 20, 1960</b> , to <b>April 21, 1960</b> , that (I) (we) last saw the deceased give an <b>April 21, 1960</b> , and that death occurred at <b>2:35</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Glenn Speicher</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/21/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. Glenn Speicher M.D.</b>				22d. ADDRESS <b>Westminster Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-24-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Morgan Chapel Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll Co. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. WALTZ, Winfield, Maryland</b>				ADDRESS <b>C. M. WALTZ, Winfield, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 25 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

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WASHINGTON, D. C. 20535



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

4400

64342

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b>		c. LENGTH OF STAY IN Tb <b>3 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - SYKESVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FULLEN NURSING HOME</b>				d. STREET ADDRESS <b>LIBERTY ROAD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAMIE ELIZABETH BURKE</b>				4. DATE OF DEATH Month Day Year <b>APRIL 23 1960</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 15 1876</b>		9. AGE (In years last birthday) yrs. <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HIRAM ENOS</b>				14. MOTHER'S MAIDEN NAME <b>MARY BOYER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>Mrs CHAS. GRISWOLD - SYKESVILLE, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident, Left side</b> DUE TO <b>1956</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cumulative arteriosclerosis generalized.</b> DUE TO <b>70</b> (c) <b>Car Use failure</b> DUE TO <b>1900</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1956</b> <b>70</b> <b>1900</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> 19 <b>23 April</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>23 April</b> 19 <b>60</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Howard E. Hall</b>				22b. DATE SIGNED <b>4/25/60</b>		22c. PHYSICIAN'S NAME (Type) <b>HOWARD E. HALL</b>	
22d. ADDRESS <b>SYKESVILLE, MD.</b>				22e. ADDRESS <b>SYKESVILLE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-26-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WARD'S CHAPEL</b>		23d. LOCATION (City, town, or county) (State) <b>HALBROOK BALTO. Co. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Height</b>				25a. REC'D BY REGISTRAR <b>APR 27 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hance</b>	

1977

RECEIVED

1977

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RECEIVED

1977

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TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64343

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural (Sykesville)</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rt. 1, Emerald Drive</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>New York (28)</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>345 E. 92nd St.,</b> d. STREET ADDRESS <b>345 E. 92nd St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margarete</b> First <b>Margarete</b> Middle <b>Dee</b> Last <b>Cohn</b>		4. DATE OF DEATH <b>April 11, 1960</b> Month <b>April</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>Fem.</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1597</b> 9. AGE (In years, months, days) <b>63</b> yrs. <b>63</b> yrs. <b>63</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>and</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Segmund Wolf</b>		14. MOTHER'S MAIDEN NAME <b>Ida</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>12-123456789</b>	
17. INFORMANT <b>Philly Lerner</b>		Address <b>345 E. 92nd St.,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO (b) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>1960</b> Hour <b>10</b> e.m. <b>10</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE <b>W. Bradley King, Jr.</b> EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		DATE SIGNED <b>April 12, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 14/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Charles Ammon</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR <b>Joe Lerner</b>		24a. REC'D BY REGISTRAR <b>APR 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		24c. ADDRESS <b>6000 Reister Road</b>	

4th

4387

## CERTIFICATE OF DEATH

4344

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>		d. STREET ADDRESS <u>528 Orkney Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>ABRAHAM</u> Middle <u>G.</u> Last <u>COLE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1960</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1870</u>
9. AGE (In years lost birthday) yrs <u>90</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Collector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Abraham Cole</u>		14. MOTHER'S MAIDEN NAME <u>Matilde Sparks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>Mr. Edwin H. Cole - 4208 Tuscany Court</u>		Address <u>Balto. 10, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>57</u> , to <u>May 18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>60</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W H Foard M.D.</u>		DATE SIGNED <u>4-18-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Lickner &amp; Sons - Balto</u>		24a. RECEIVED BY REGISTERED <u>17 Md</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

421



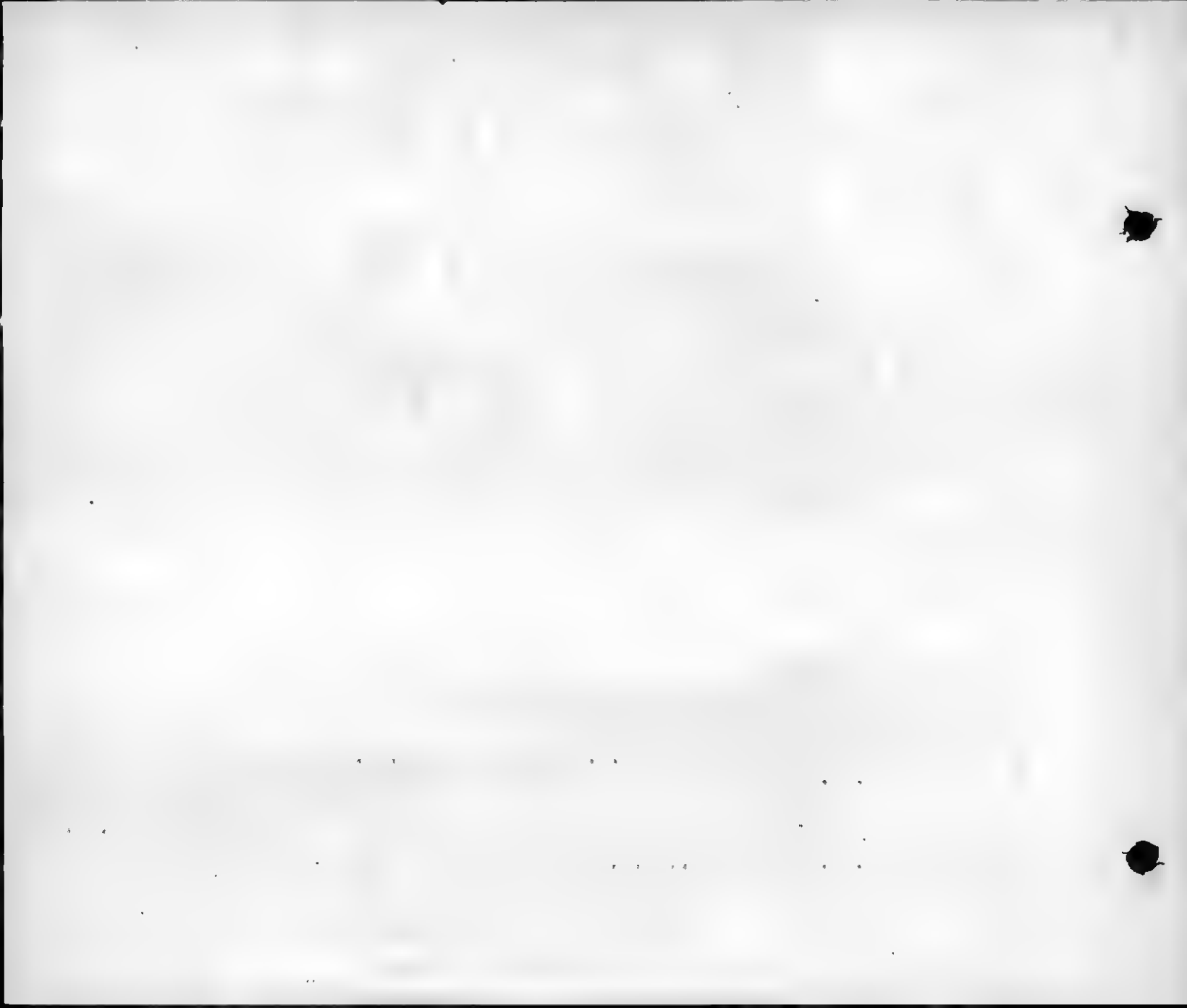
**MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18 64345**  
**4402**  
**CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Louisa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Grand View Nursing Convalescent</u>		d. STREET ADDRESS <u>508 Park Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Loane</u> Last <u>Corman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>N York Co Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Wiley Gemmell</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Anna Curry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Bernard Thomas Gostrom</u> Address <u>49</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PARALYSIS AGITANS</u> 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>4.3.1954</u> , 19____, to <u>4.29.1960</u> , 19____, that I last saw the deceased alive on <u>4.28.60</u> , 19____, and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. H. Lawson, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>4.29.60</u>	
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>		<u>Sykesville-2, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>5/1/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	22d. LOCATION (City, town, or county) (State) <u>Hammer Pa York Co</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Becker</u> ADDRESS <u>Hammer Pa</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 2 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Caroline E. Hume</u>

MEDICAL CERTIFICATION

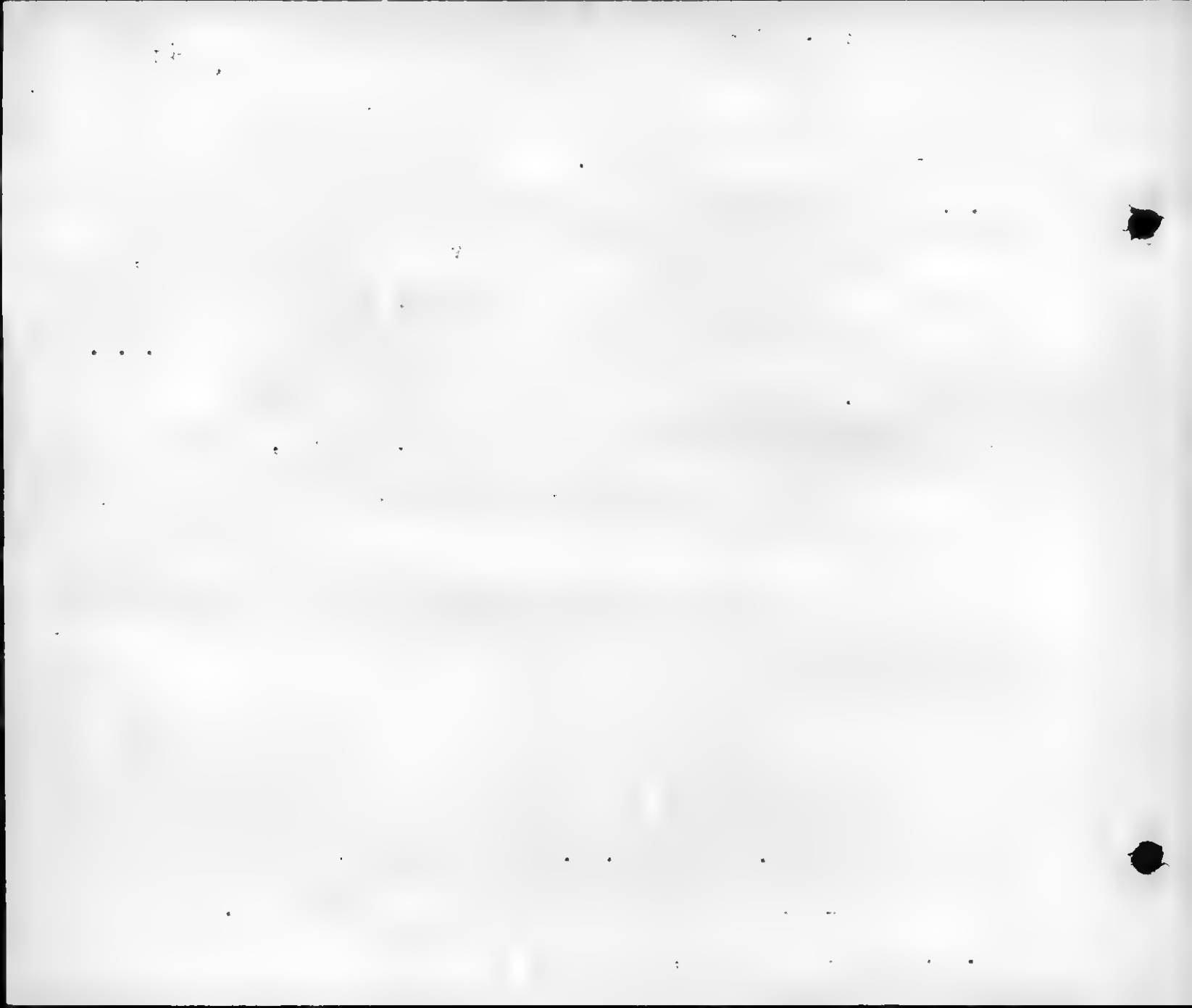
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4403  
CERTIFICATE OF DEATH  
64346

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Carroll</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--</b>		c. LENGTH OF STAY IN 1b <b>12 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. 6 Westminster</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-- Westminster</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GENEVA AGNES COSTLEY</b>		4. DATE OF DEATH Month Day Year <b>April 6, 1960</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 27, 1890</b> 69 yrs
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
10a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
12. FATHER'S NAME <b>Allen T. Collins</b>		13. MOTHER'S MAIDEN NAME <b>Hannah Gosnell</b>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>*****</b>		15. SOCIAL SECURITY NO. <b>*****</b>	
16. INFORMANT <b>Clarence C. Costley,</b>		Address <b>Same</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage massive,</b> <b>470.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease, arteriosclerosis</b> DUE TO (c) <b>Generalized, diabetic, mild.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1956 to 6 April 60</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> 19 <b>6 April</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>6 April 1960</b> , and that death occurred at <b>3:40 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Howard E. Hall</b>		22b. DATE SIGNED <b>6 April 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>HOWARD E. HALL M. D.</b>		22d. ADDRESS <b>Adamsville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-10-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Johnsville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		25a. REC'D BY REGISTRAR <b>DATE APR 11 '60</b>	
ADDRESS <b>Winfield, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>	



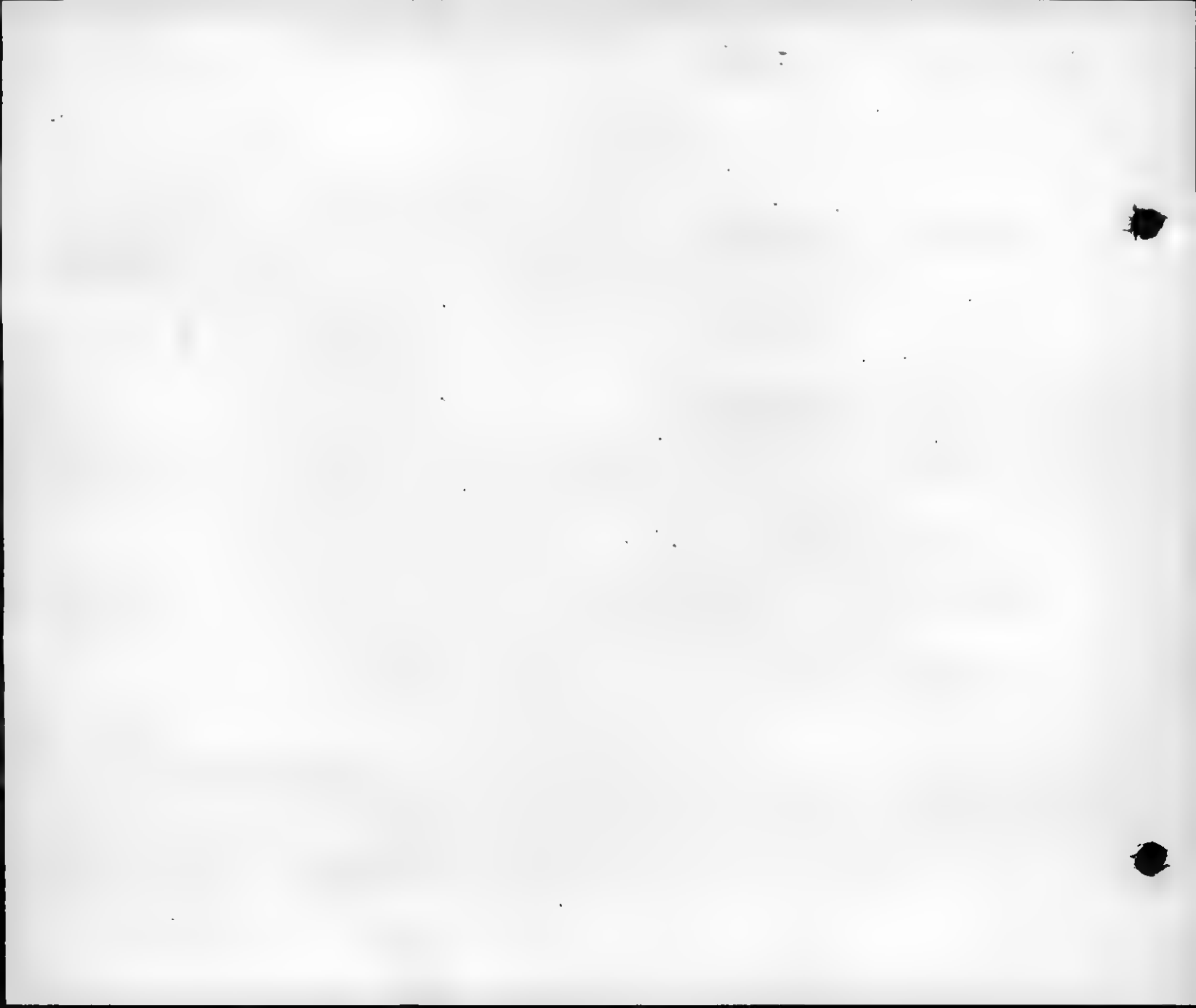
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**4404 CERTIFICATE OF DEATH**

64347

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>		c. LENGTH OF STAY IN 1b <u>1 Month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Golden Age Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT H. CROSS</u>		4. DATE OF DEATH Month Day Year <u>April 28 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>John W. Cross</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Wilcox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Wanda E. Cross, West Friendship, MD</u>		Address <u>West Friendship, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Heart - Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 13 1960</u> to <u>April 28 1960</u> that (I) (we) last saw the deceased alive on <u>April 27 1960</u> and that death occurred at <u>MD</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Thomas H. Martin</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DR. P. L. A. ST. J.</u>		22d. ADDRESS <u>Laurel, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>May 2, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West View</u>	23d. LOCATION (City, town, or county) (State) <u>Laurel, Anne Arundel, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Hargett</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 3 '60</u>	
ADDRESS <u>Crysanville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hargett</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





4390

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Hill</u>				d. STREET ADDRESS <u>College Hill</u>			
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>MARY</u> Middle <u>CUNNINGHAM</u> Last				4. DATE OF DEATH <u>17 APRIL 1960</u> Month <u>17</u> Day <u>APRIL</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26 1870</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Md, U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Dr. Henry T. Mother</u>				14. MOTHER'S MAIDEN NAME <u>Mary Louise Reddick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mary Louise Reddick</u> Address <u>Westminster Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 14 1960</u> to <u>April 14 1960</u> , that I last saw the deceased alive on <u>April 14 1960</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kemper Westminste Md</u> DATE SIGNED <u>4/17</u>							
ACTUAL SIGNATURE <u>G. Reese Wilkens</u> M.D.				22a. REC'D BY REGISTRAR <u>APR 18 '60</u>			
PHYSICIAN'S NAME (Type) <u>G. Reese Wilkens</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			
22b. DATE THEREOF <u>April 18, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Md</u>		22d. LOCATION (City, town, or county) (State)		24a. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Thompson</u> ADDRESS <u>Westminster Md</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4405  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

64349

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hosp.</i>		d. STREET ADDRESS <i>1200 Valley Str. Balt: 2</i>	
4. NAME OF DECEASED (Type or print) <i>Mary</i> First <i>Catherine</i> Middle <i>Determan</i> Last		4. DATE OF DEATH <i>4-22-1960</i> Month <i>4</i> Day <i>22</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-9-1869</i>
9. AGE (In years last birthday) <i>90</i> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>not listed</i>		14. MOTHER'S MAIDEN NAME <i>not listed</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-10-2051</i>	
17. INFORMANT <i>Records of Springfield St. Hosp. Sykesville</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia and</i> <i>493X</i> DUE TO <i>asthmatic Cardio-Vascular Dy.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome assoc. senile brain disease with psychotic r-n.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <i>12-10-1957</i> to <i>4-22-1960</i> , that (H) (we) last saw the deceased alive, on <i>4-22-1960</i> and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Konstantin Weber</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Konstantin WEBER</i> M.D.		22d. ADDRESS <i>Oak Str Sykesville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>Apr. 27/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Philip Herwig</i>		25a. REC'D BY REGISTRAR <i>APR 28 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur J. H...</i>			

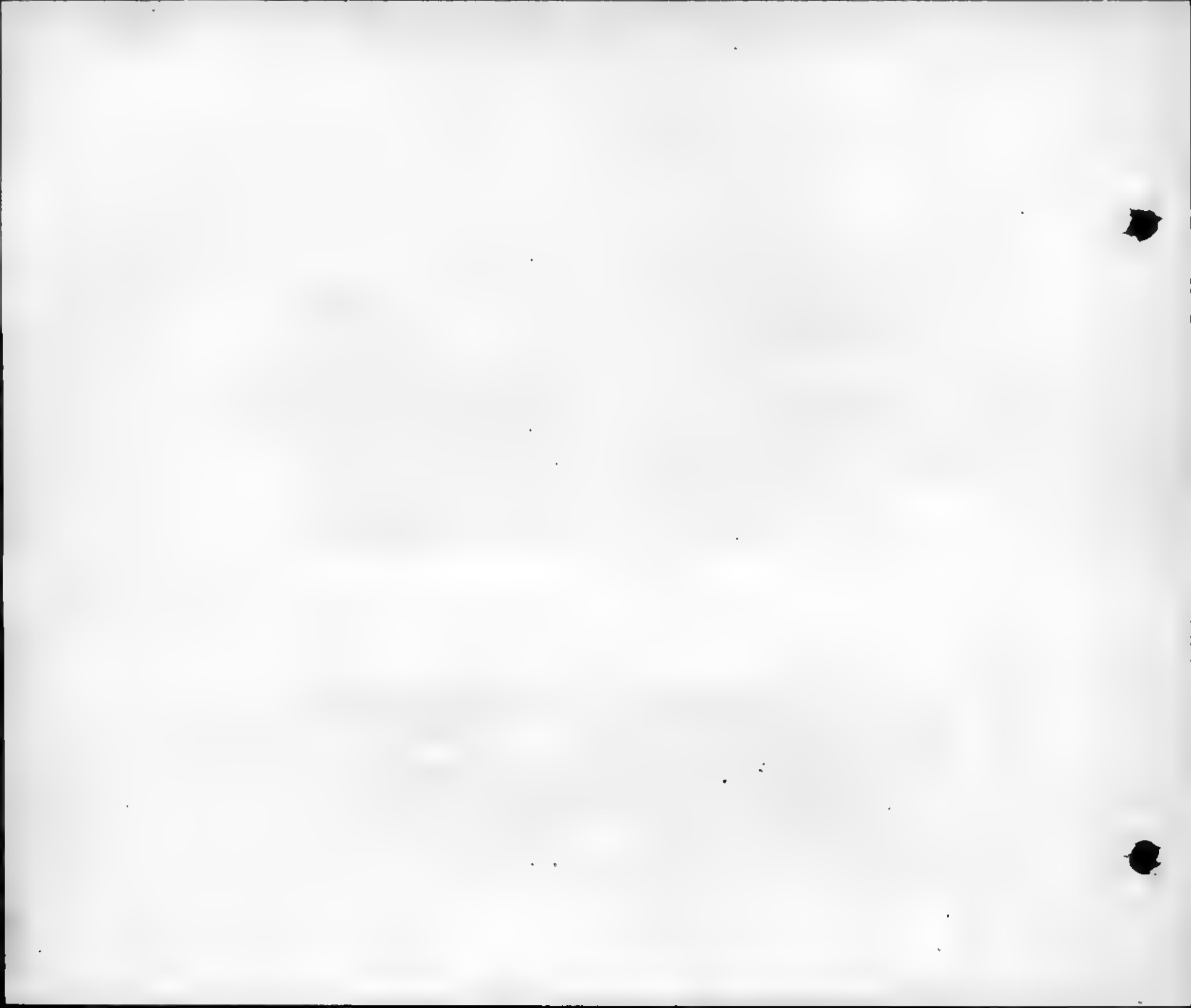


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
Items 5&6 Film 0261 4/25/60 c											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>8 yrs 1 mo</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Springfield State Hospit.</i>				e. STREET ADDRESS <i>4717 Conington Str.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Edna</i> First <i>Louise</i> Middle <i>Dowling</i> Last				4. DATE OF DEATH <i>4-16-1960</i> Month <i>4</i> Day <i>16</i> Year <i>1960</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-14-1898</i> Yrs <i>62</i>		9. AGE (In years last birthday) <i>62</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>house hold</i>				11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles France</i>				14. MOTHER'S MAIDEN NAME <i>Mary Harvey</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Hospital records, Springfield St. Ho.</i> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1-Arteriosclerotic cardiovascular disease</i> <i>442X</i> (b) <i>2- Nephrosclerosis with hydronephrosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Schizophrenic reaction, hebephrenic type.</i>										INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Schizophrenic reaction, hebephrenic type.</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 5, 1958</i> to <i>4-16-1960</i> , that (I) (we) last saw the deceased alive on <i>4-16-1960</i> and that death occurred at <i>8:43 AM</i> from the causes and on the date stated above											
22a. SIGNATURE <i>Konstantin Weber</i> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		DATE SIGNED <i>4-17-1960</i>					
22c. PHYSICIAN'S NAME (Type) <i>Konstantin WEBER</i> M.D.				22d. ADDRESS <i>Oak Str. Sykesville, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		23b. DATE THEREOF <i>4-20-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WESTERN</i>				23d. LOCATION (City, town, or county) (State) <i>Balto.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>McClary - 1-30 C Tol - 1-22</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>APR 20 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. H...</i>			





1  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4407  
CERTIFICATE OF DEATH

04351

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>5yrs. 5mos. 3days</b>		d. STREET ADDRESS <b>808 E. North Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Newton</b> Last <b>Ellis</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <del>NEVER MARRIED</del> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1904</b>
9. AGE (In years last birthday) <b>55</b> yrs.	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>14</b> Hours <b>14</b> Min.	11. IF UNDER 24 HRS Months <b>5</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ordnance for Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Ellis</b>		14. MOTHER'S MAIDEN NAME <b>Blanche</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>465X</b> (b) <b>Multiple hemorrhagic infarctions of lungs</b> (c) <b>Thrombosis of Liliac &amp; vena cava superior vein</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>weeks</b> <b>days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.E.S. assoc. with alcohol intoxication with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 11, 1954</b> to <b>April 14, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 14, 1960</b> and that death occurred at <b>1:40 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE <b>4/14/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/16/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry Witzke</b>		25a. REC'D BY REGISTRAR <b>4/15/60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

4/10 X

4408

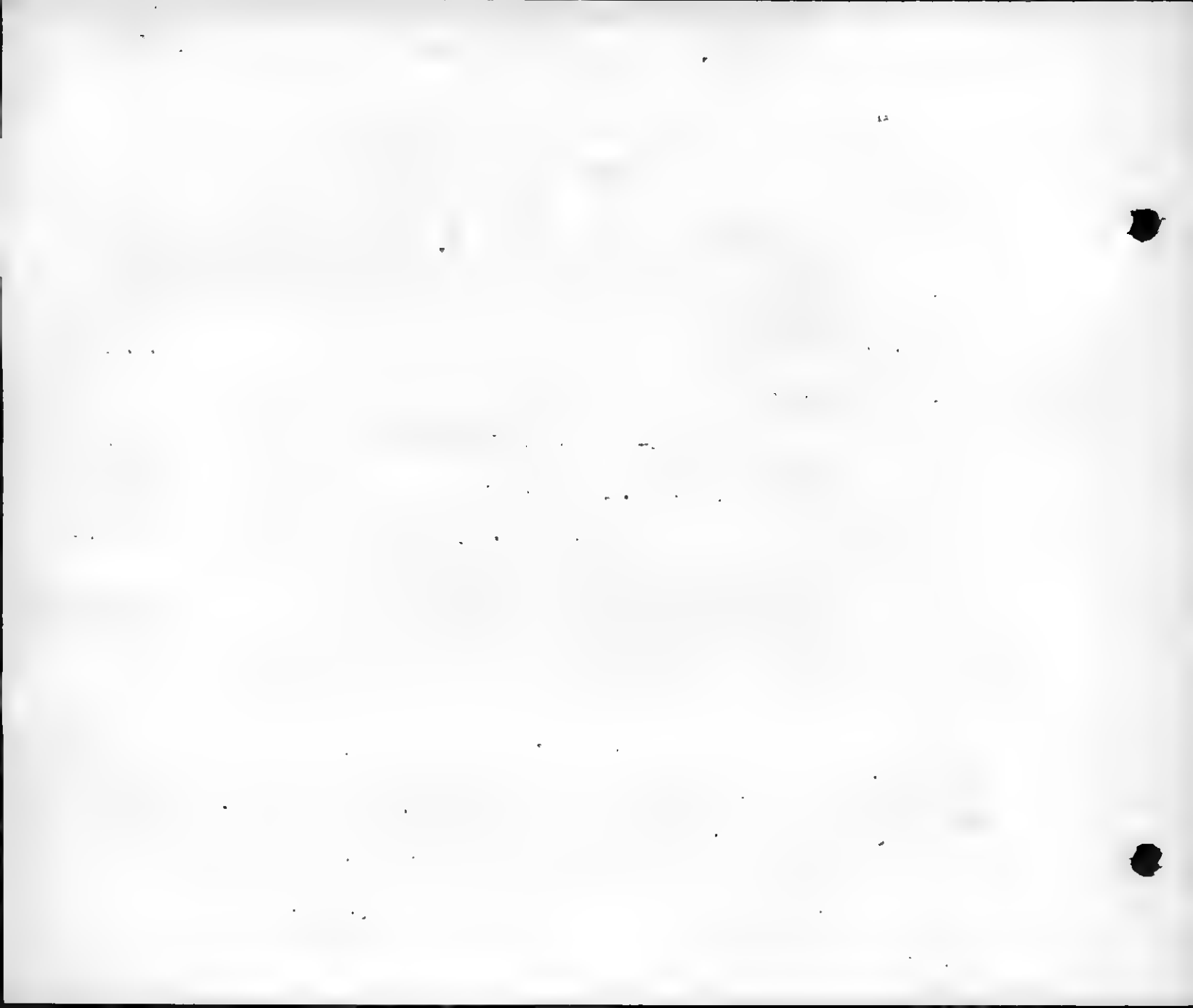
CERTIFICATE OF DEATH

64352

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Uniontown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bailey</b> Middle <b>Augustus</b> Last <b>Fleagle</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 6, 1892</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min <b>68</b>		11. IF UNDER 24 HRS Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min <b>68</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Repair</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Theodore Fleagle</b>				14. MOTHER'S MAIDEN NAME <b>Martha Williams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-10-9115</b>			
17. INFORMANT <b>Mrs. Bailey Fleagle, Uniontown, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of lung</b> DUE TO (c) <b>15 mos</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 mos</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 9, 1959</b> to <b>April 5, 1960</b> , that I lost saw the deceased alive on <b>April 5, 1960</b> , and that death occurred at <b>6:45 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>55 1/2 W Green St Uniontown, Md.</b> DATE SIGNED <b>4/6/60</b>							
ACTUAL SIGNATURE <b>Julius Chapko</b> M.D.				PHYSICIAN'S NAME (Type) <b>Julius Chapko</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>April 7, 1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Church of God</b>				22d. LOCATION (City, town, or county) (State) <b>Uniontown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> <b>C. F. Fuss &amp; Son Taneytown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 8 1960</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur A. Thomas</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4409

CERTIFICATE OF DEATH

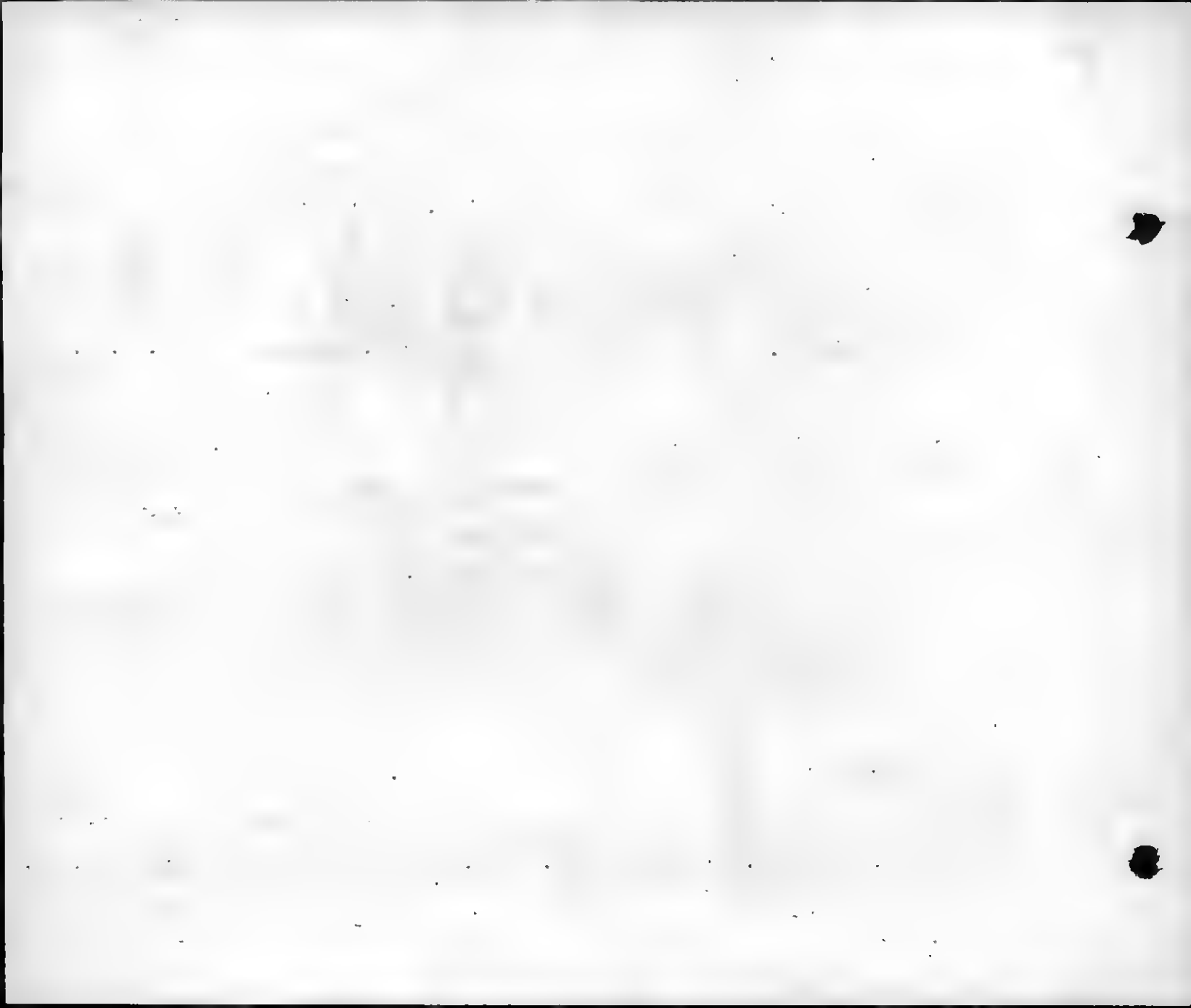
64353  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>425 W. Biddle Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sims</b> Middle <b>Forrest</b> Last <b>Forrest</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 23, 1918</b>
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months <b>41</b> Days <b>41</b> Hours <b>41</b> Min <b>41</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>United Fruit Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Burkeville, Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joe Forrest</b>		14. MOTHER'S MAIDEN NAME <b>Virlie Booker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> War <b>II</b>		16. SOCIAL SECURITY NO. <b>230-01-7281</b>	
INFORMANT <b>Sims Forrest-Patient</b>		Address <b>425 W. Biddle Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> DUE TO <b>Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Far advanced bilateral cavitary TB</b> (b) <b>Far advanced bilateral cavitary TB</b> (c) <b>Far advanced bilateral cavitary TB</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 14, 1960</b> to <b>April 22, 1960</b> that I last saw the deceased alive on <b>April 22, 1960</b> , and that death occurred <b>5:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>4-22-60</b>			
ACTUAL SIGNATURE <b>S. M. Maculans, M.D.</b>		M.D. <b>Henryton, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt.</b>		<b>Henryton State Hospital, Henryton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>APR 25 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Burkeville, Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dr. Edgars M. Maculans</b>		24a. REC'D BY REGISTRAR <b>APR 26 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





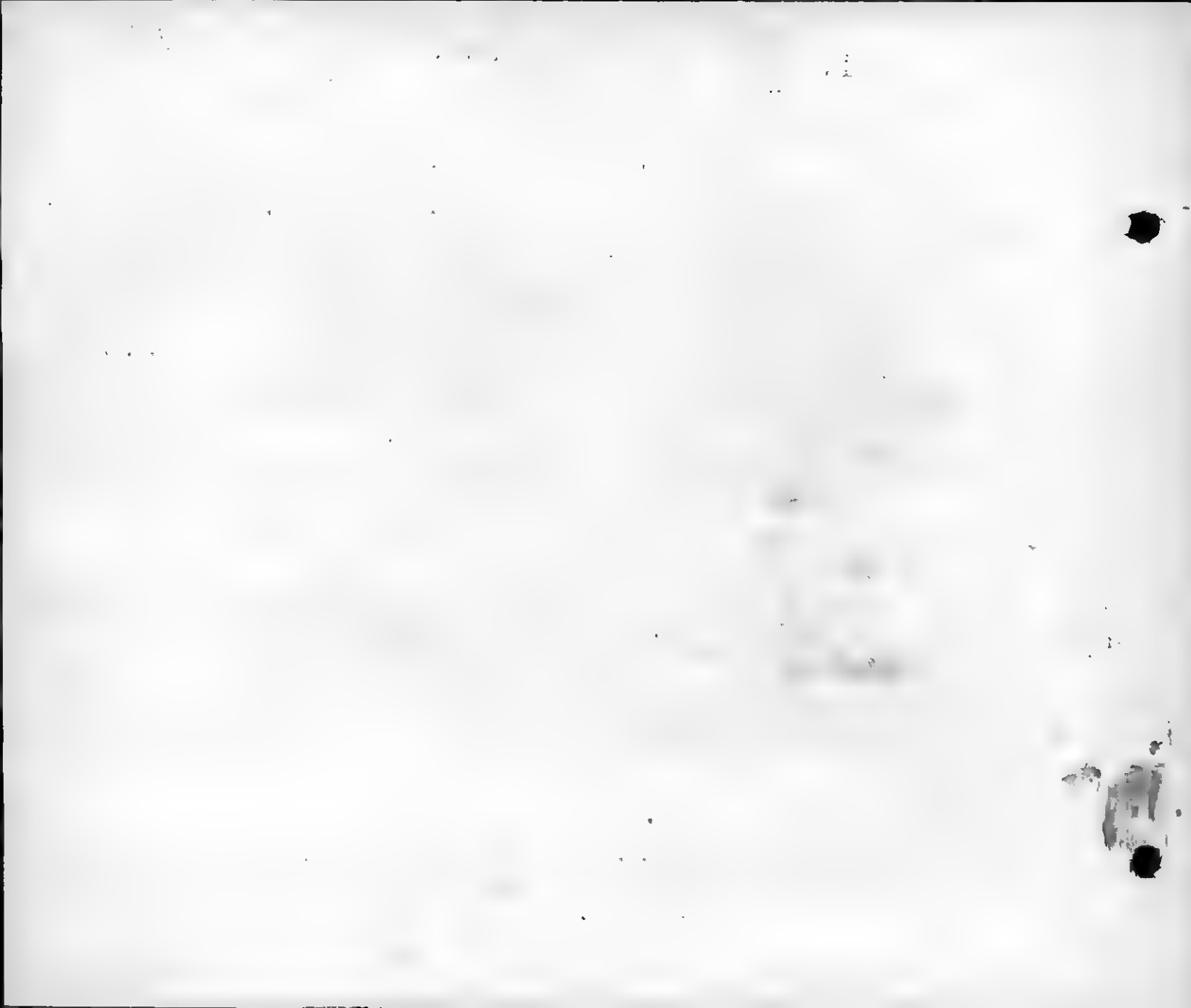
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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64354

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4418  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b></b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>9 mo. 4 days</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1108 W. Baltimore St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>-</b> Last <b>Foss</b>				4. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>9/26/93</b>		9. AGE (In years last birthday) <b>66</b> yrs	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph William Ross</b>				14. MOTHER'S MAIDEN NAME <b>Ida Florence McCauley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome assoc. with cerebral arteriosclerosis with psychosis</b>							19. WAS AUTOPSY PERFORMED? <b>NO</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/9/59</b> to <b>4/4/60</b> , that (I) (we) last saw the deceased alive on <b>4/4/60</b> and that death occurred at <b>2:28 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Konstantin Weber</b>				M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/5/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Konstantin Weber, M.D.</b>				22d. ADDRESS <b>Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-8-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kilbuck</b>		23d. LOCATION (City, town or county) (State) <b>Waynesboro, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight</b>				ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 7 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>William E. Turner</b>	



4391

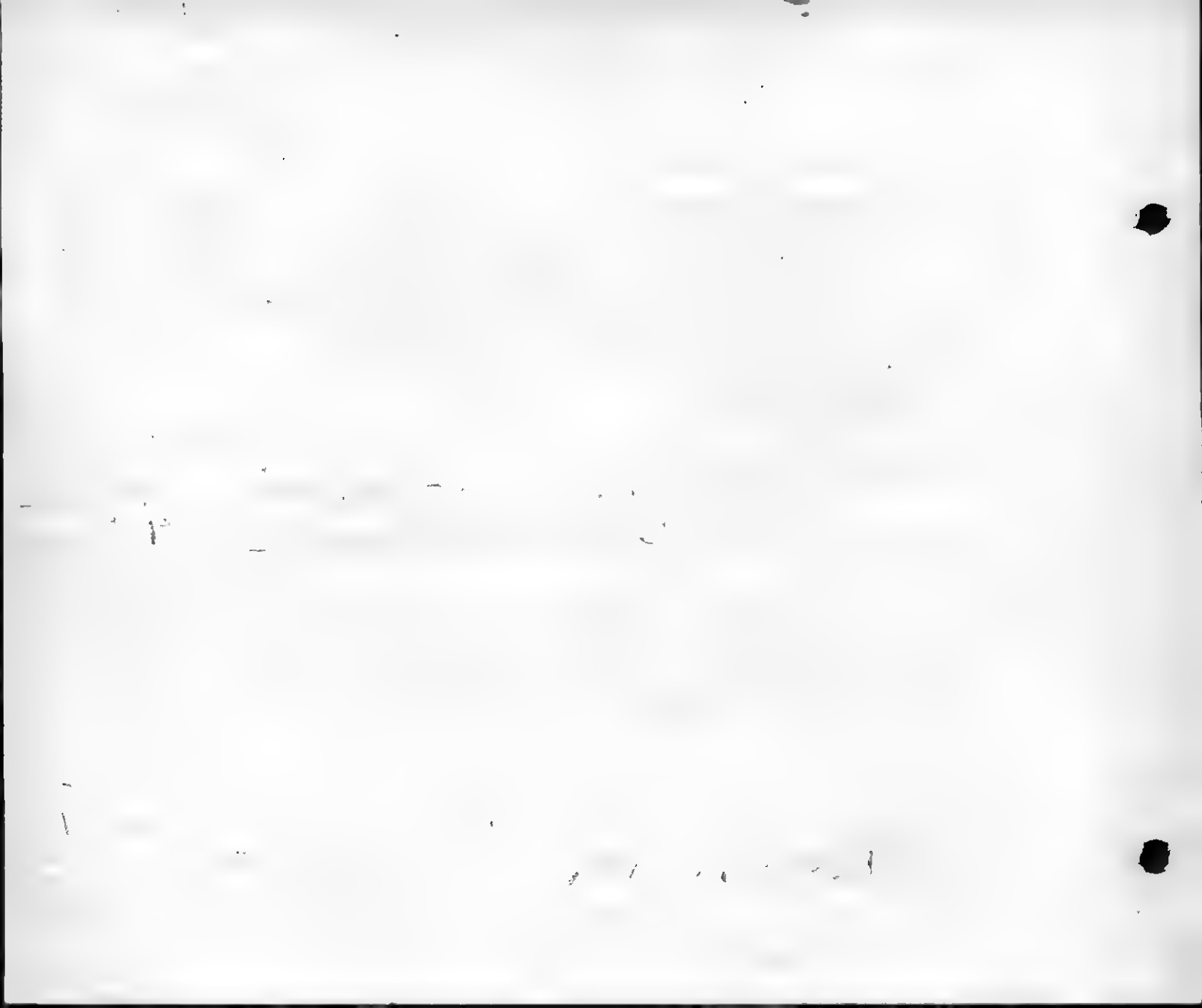
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL CO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CARROLL CO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER MD.</b>		c. LENGTH OF STAY IN 1b <b>6 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>IBEX NURSING HOME</b>		d. STREET ADDRESS <b>?</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD NORMAN GREEN</b>		4. DATE OF DEATH Month <b>4</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/10/1872</b>
9. AGE (In years last birthday) <b>88</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MANUFACTURING</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM GREEN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA. - ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO <b>—</b>	
17. INFORMANT <b>IBEX NURSING HOME</b>		Address <b>WESTMINSTER</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4301</b> <b>Coronary occlusion</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>9 + yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1954</b> to <b>Apr 30, 1960</b> that I last saw the deceased alive on <b>Apr 30, 1960</b> and that death occurred at <b>11 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. Reese Wilkens</b> M.D.		ADDRESS (Street, city or town, state) <b>15 Kemper Ave Westminister Md.</b>	
DATE SIGNED <b>5/1/60</b>			
PHYSICIAN'S NAME (Type) <b>E. Reese Wilkens</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/3/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MEADOW BRANCH CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WESTMINSTER MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Saffell</b>		ADDRESS <b>WESTMINSTER MD.</b>	
24a. REC'D BY REGISTRAR <b>MAY 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Hump</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.



4388

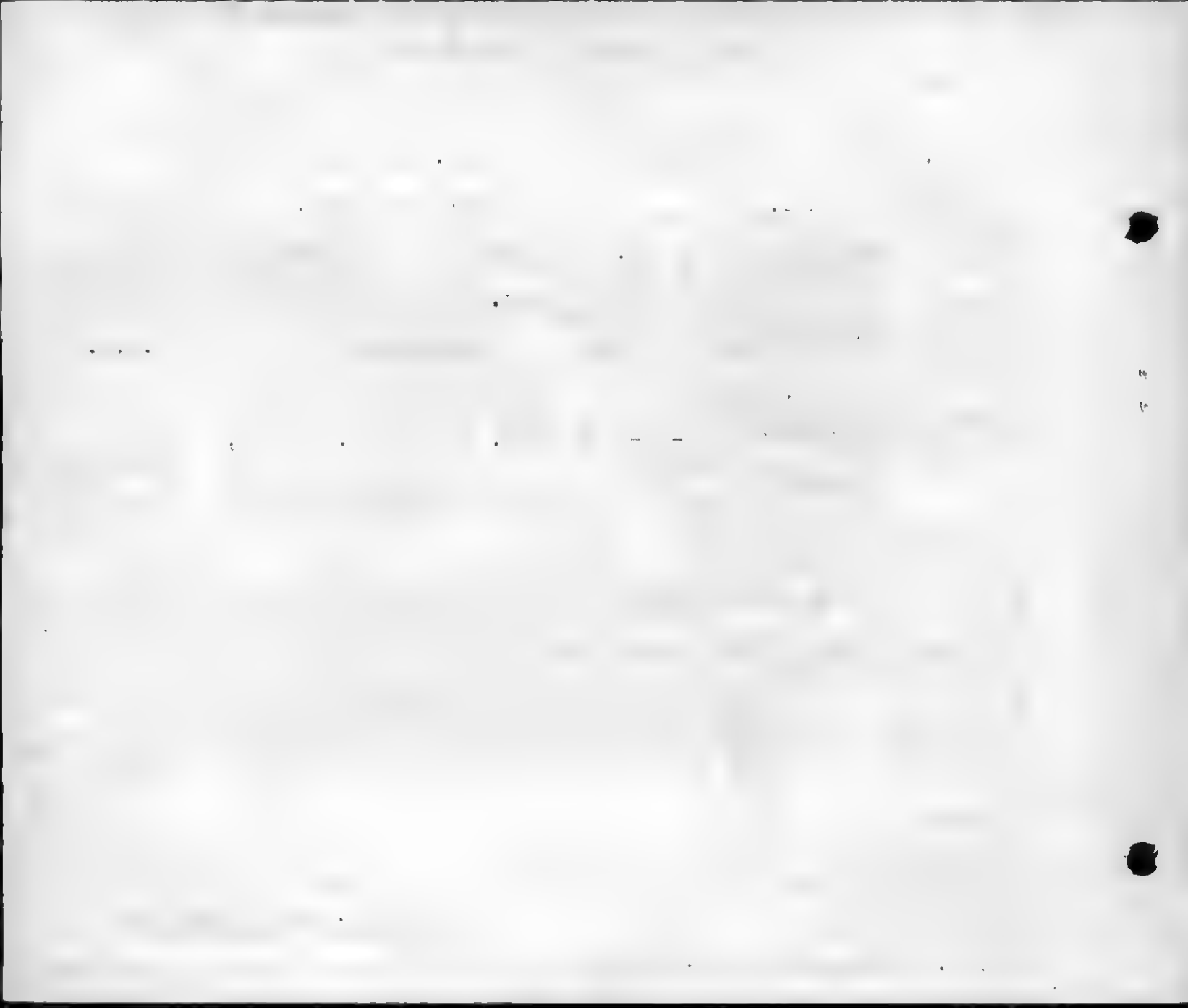
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bellview Ave.</b>		e. STREET ADDRESS <b>Bellview Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>WILFORD</b> First <b>E.</b> Middle <b>HOBBS</b> Last		4. DATE OF DEATH <b>April</b> Month <b>6,</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 9, 1877</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Grain Inspector-- Mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Norvall W. Hobbs</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Gilbert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>*****</b>		16. SOCIAL SECURITY NO. <b>213-01-5620</b>	
17. INFORMANT <b>Mrs. Nannie A. Hobbs, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chron. Myocarditis</b> (c) <b>Bronchial Asthma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>3 yrs</b> <b>30 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1920</b> to <b>Apr 6, 1960</b> , that I last saw the deceased alive on <b>Apr 6, 1960</b> and that death occurred at <b>7:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. M. Waltz</b> M.D.		ADDRESS (Street, city or town, state) <b>Winfield, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>C. M. Waltz</b>		DATE SIGNED <b>4/7/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 9, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cemetary</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Airy, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. WALTZ, Winfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 11 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>Edmund A. Havel</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4411

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64357

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Westminster</b>				c. LENGTH OF STAY IN lb <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D. # 6</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural--Westminster</b>			
f. STREET ADDRESS <b>Old Washington Road</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>M.</b> Middle <b>EVELYN</b> Last <b>HOOK</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>10</b> Year <b>19 60</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-3-1914</b>	
9. AGE (in years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>David Grant Hook</b>				14. MOTHER'S MAIDEN NAME <b>Louisa M. Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-10-7766</b>		17. INFORMANT <b>Wm. G. Hook</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>MIN</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James J. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-13-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Deer Park</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>				ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 13 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carlton J. F...</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

420



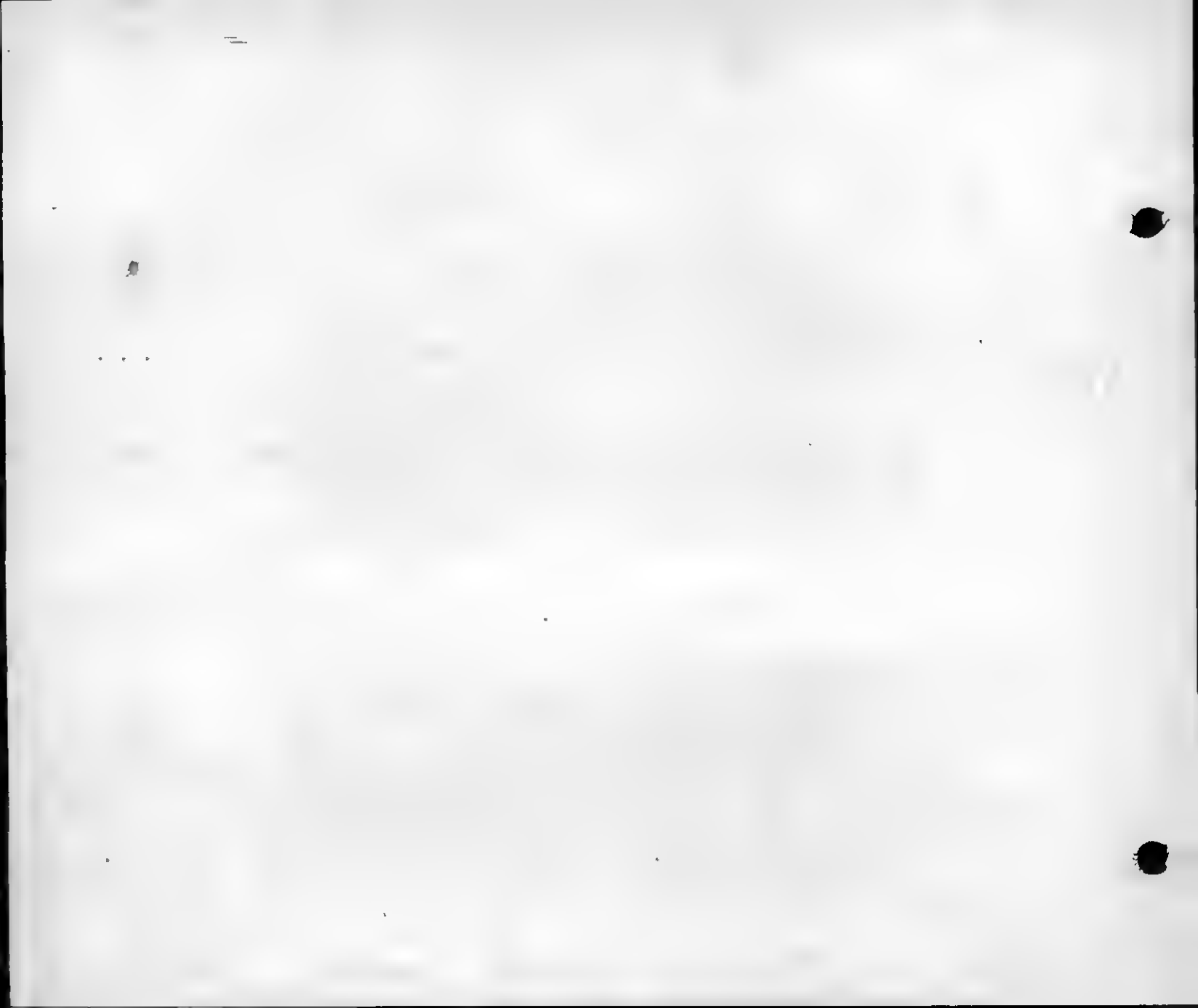
11

15

1

## 64358

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>11 mos. 5 days</b>		4. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2711 Dundalk Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Emilia</b>		Middle <b>Louise</b>		Last <b>Hornak</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1896</b>		9. AGE (In years last birthday) <b>63 yrs</b>	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Bendoline</b>				14. MOTHER'S MAIDEN NAME <b>Pauline -</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>176X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of breast with metastasis</b> DUE TO Candilans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 12, 1959</b> , to <b>April 17, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 17, 1960</b> , and that death occurred at <b>6:10 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Edmund Lusthaus</b> M.D.				22b. DATE SIGNED <b>4/18/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>			
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>									
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/20/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		23d. LOCATION (City, town, or county) (State) <b>BALTC. Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER BROOKS BRADLEY, INC. - DUNDALK 22, MD.</b>				25a. REC'D BY REGISTRAR <b>DATE 4-20-60</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton E. Harris</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4413

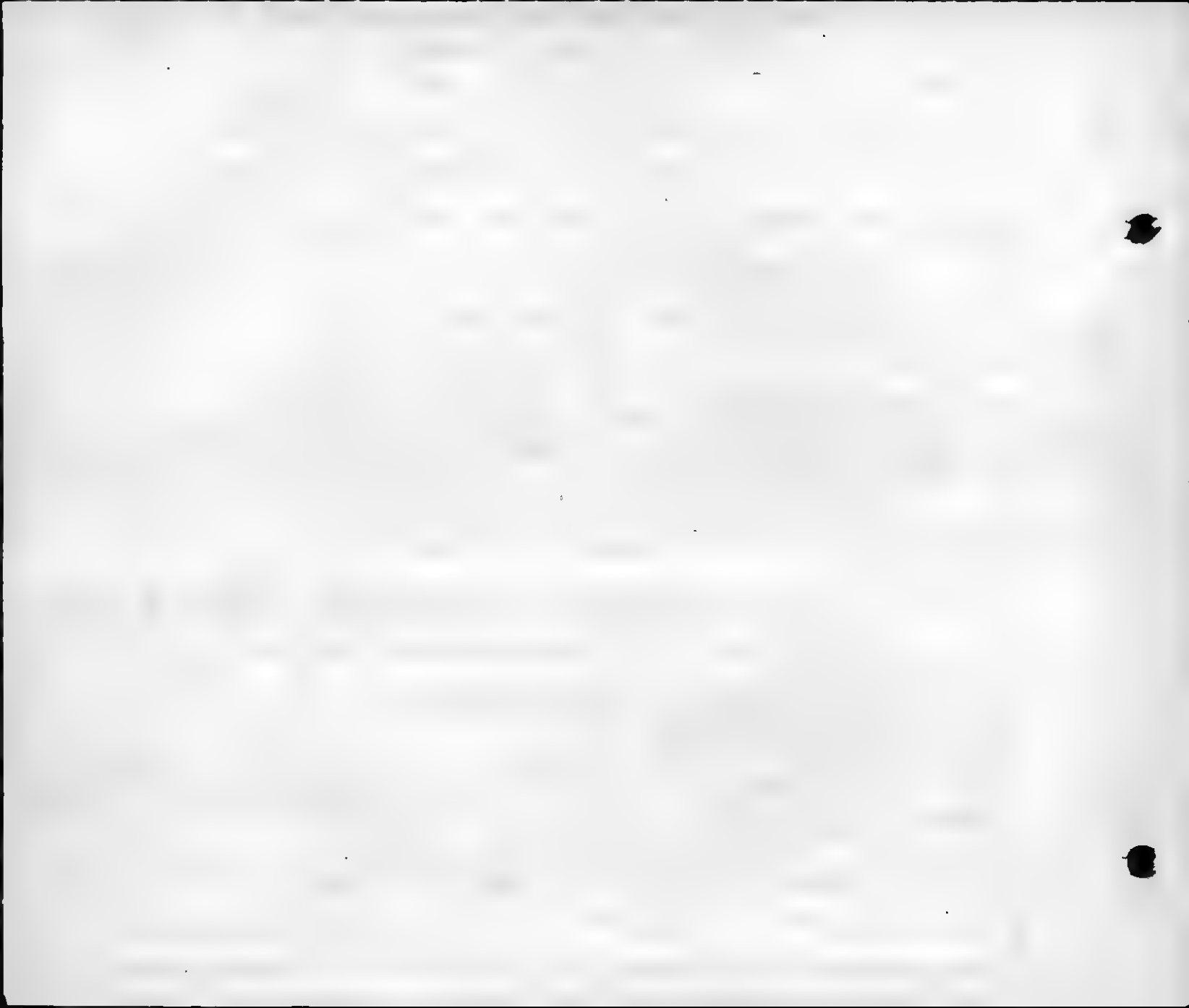
## CERTIFICATE OF DEATH

64359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>				c. LENGTH OF STAY IN 1b <u>DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MIDDLEBURG</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>			
f. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ALBERT HORTON</u>				4. DATE OF DEATH Month Day Year <u>APR 23 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 8 - 1875</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>IRA HORTON</u>				14. MOTHER'S MAIDEN NAME <u>HARRIETT WRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>WILLARD HORTON MT AIRY RURAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 w.</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/21/60</u> 19 <u>60</u> , to <u>4/23/60</u> 19 <u>60</u> , that I last saw the deceased alive on <u>4/22/60</u> 19 <u>60</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D. <u>New Windsor, Md</u> <u>4/23/60</u> PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u> <u>NEW WINDSOR MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>TAYLORSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W H Hartzler &amp; Sons, New Windsor</u>				24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4414  
**CERTIFICATE OF DEATH**  
04360

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>37y 6m 7d</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>JANE</b> Last <b>HUMBERT</b>				4. DATE OF DEATH Month <b>4</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-24-94</b>	
9. AGE (In years last birthday) <b>65</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John C. Bollinger</b>				14. MOTHER'S MAIDEN NAME <b>Elvira Keagy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Records of Springfield State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardio-vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, catatonic type</b>						INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>9-18</b> <b>1952</b> to <b>4-13-60</b> , 19____, that (I) (we) last saw the deceased alive on <b>4-13-</b> <b>1960</b> , and that death occurred at <b>2:50 A.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Konstantin Weber</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>KONSTANTIN WEBER</b>				22d. ADDRESS <b>Oak Street, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/16/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Nr. Littlestown, Adams Co., Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>				ADDRESS <b>Littlestown, Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

440X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

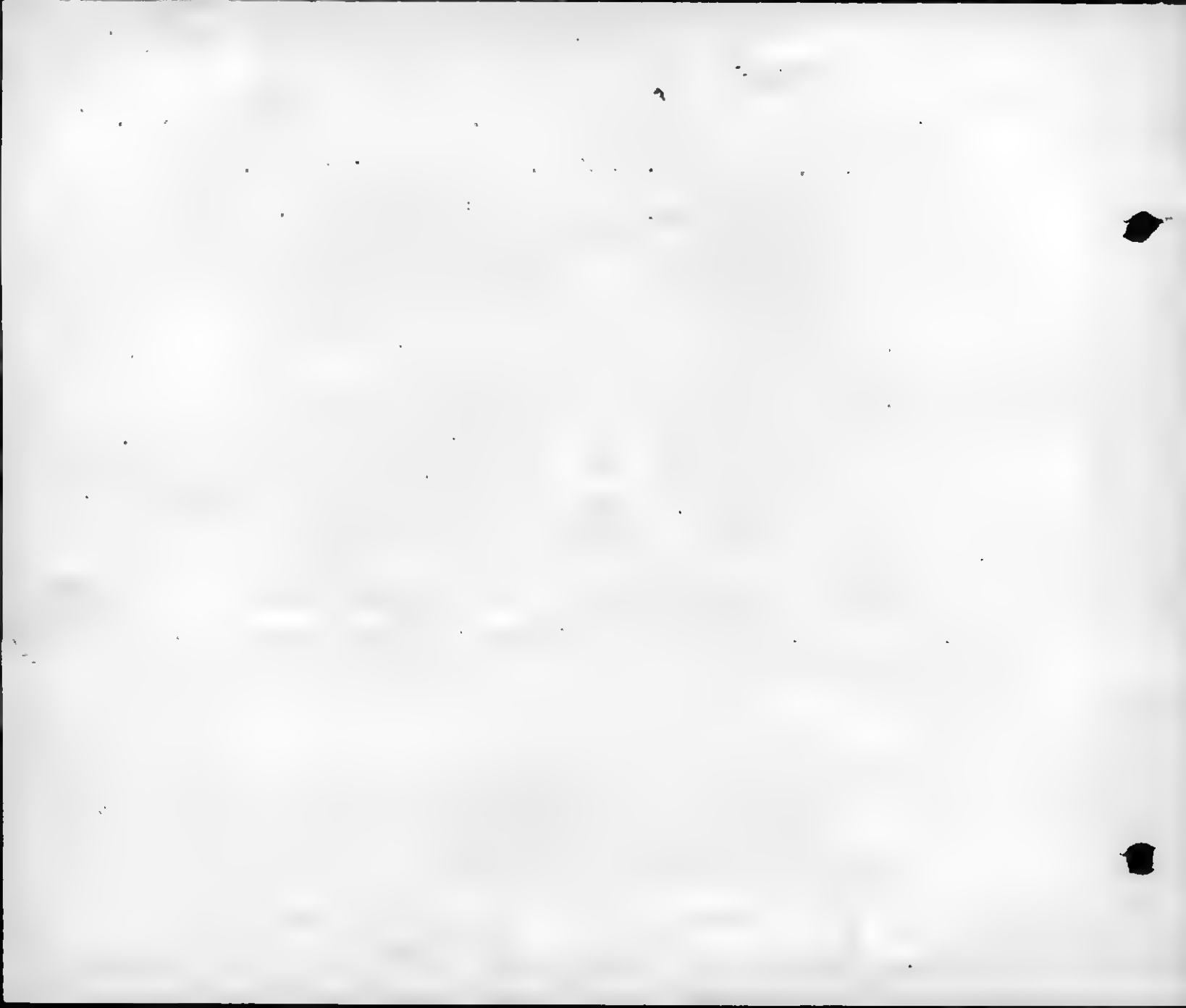
64361

4415

Item 9 filed 260 4-7-60 at

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll, Co.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Md.</b> c. LENGTH OF STAY IN 1b <b>1yr. 3mo. 24da.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery, Co. 15</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13716 Colesville Rd.</b> d. STREET ADDRESS <b>Silver Spring, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Viola</b> Middle <b>Johnson</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/28/98</b>
9. AGE (In years lost birthday) <b>72 1/2</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>26</b>	11. IF UNDER 24 HRS Hours <b>1</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John A. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Hinnie Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Springfield State Hospital Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>4. Acute and chronic myocardial infarction</b> <b>coronary arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>C.R.S.s.s.o.c. withh Convulsive disorder, with psychotic reaction.</b> INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> to <b>1960</b> that (I) (we) last saw the deceased alive on <b>4/1/1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ellis S. Margolin</b>		22b. DATE SIGNED <b>4/2/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>ELLIS S. MARGOLIN M.D.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral</b>		23b. DATE THEREOF <b>April 5, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Huns</b>		25a. REC'D BY REGISTRAR DATE <b>APR 5 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			





4416

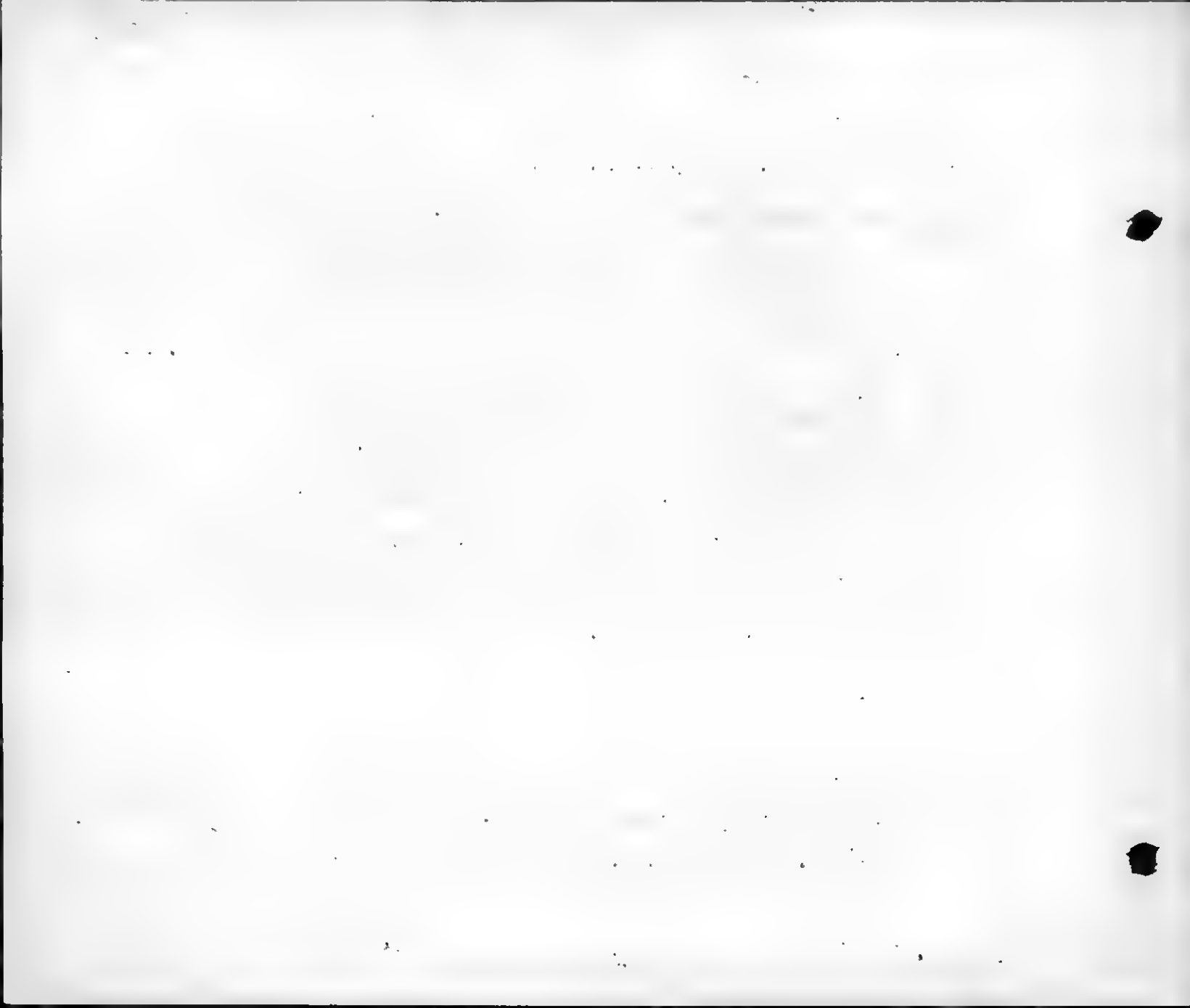
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>22yr. 11mo. 15da.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City 20 No. Castle, Balti, Md.</b>	
f. STREET ADDRESS <b>Transferred from Baltimore City Hospital</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Heimel</b> Last <b>KAPTAIN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug-15-1874</b>
9. AGE (In years lost birthday) <b>82</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Heimel</b>		14. MOTHER'S MAIDEN NAME <b>Anna Heistedder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerosis, generalized.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with arteriosclerosis.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 - week</b>  <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1953</b> to <b>April 4, 1960</b> , that I last saw the deceased alive on <b>April 3, 1960</b> , and that death occurred at <b>1:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital 4-4-60</b>			
ACTUAL SIGNATURE <b>Myron Nizankowsky</b> M.D.		PHYSICIAN'S NAME (Type) <b>Myron Nizankowsky, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>		22b. DATE THEREOF <b>Apr 7 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>4220 Belair Road Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 6 '60</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dyfel Bros</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	
ADDRESS <b>1800 E. LUXBARD ST</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

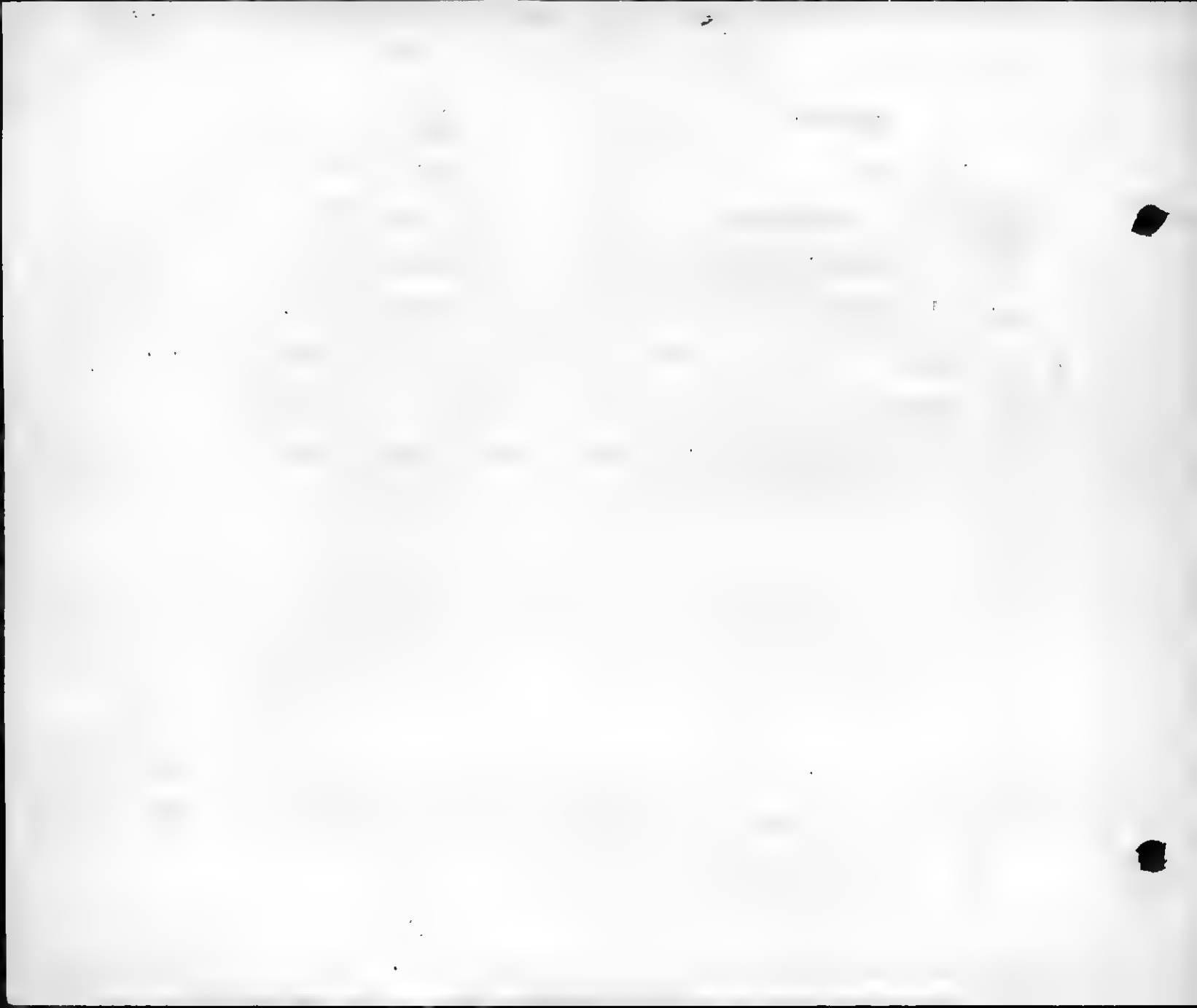


## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4417  
CERTIFICATE OF DEATH64363  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carnall</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> 03 x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#12 Barnett Avenue</u>		d. STREET ADDRESS <u>2309 Poplar Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dorothy Eileen Kelbaugh</u>		4. DATE OF DEATH Month Day Year <u>April 25, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1893</u>
9. AGE (in years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Furman Blair</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216- 34-1454</u>	
17. INFORMANT <u>Willard Sewell Kelbaugh</u>		Address <u>2309 Poplar Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> DUE TO (b) <u>Ca D RT Kidney</u> DUE TO (c) <u>Full stroke</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1950</u> to <u>7-35, 1960</u> that I last saw the deceased alive on <u>7-24, 1960</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. Shaw T. Abbott</u> M.D.		ADDRESS (Street, city or town, state) <u>4509 Liberty Heights Ave</u> DATE SIGNED <u>4-25-60</u>	
PHYSICIAN'S NAME (Type) <u>Thomas E. Abbott</u>		<u>Baltimore Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-28-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>4600 Liberty Heights Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>APR 26 1960</u>	
		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4418

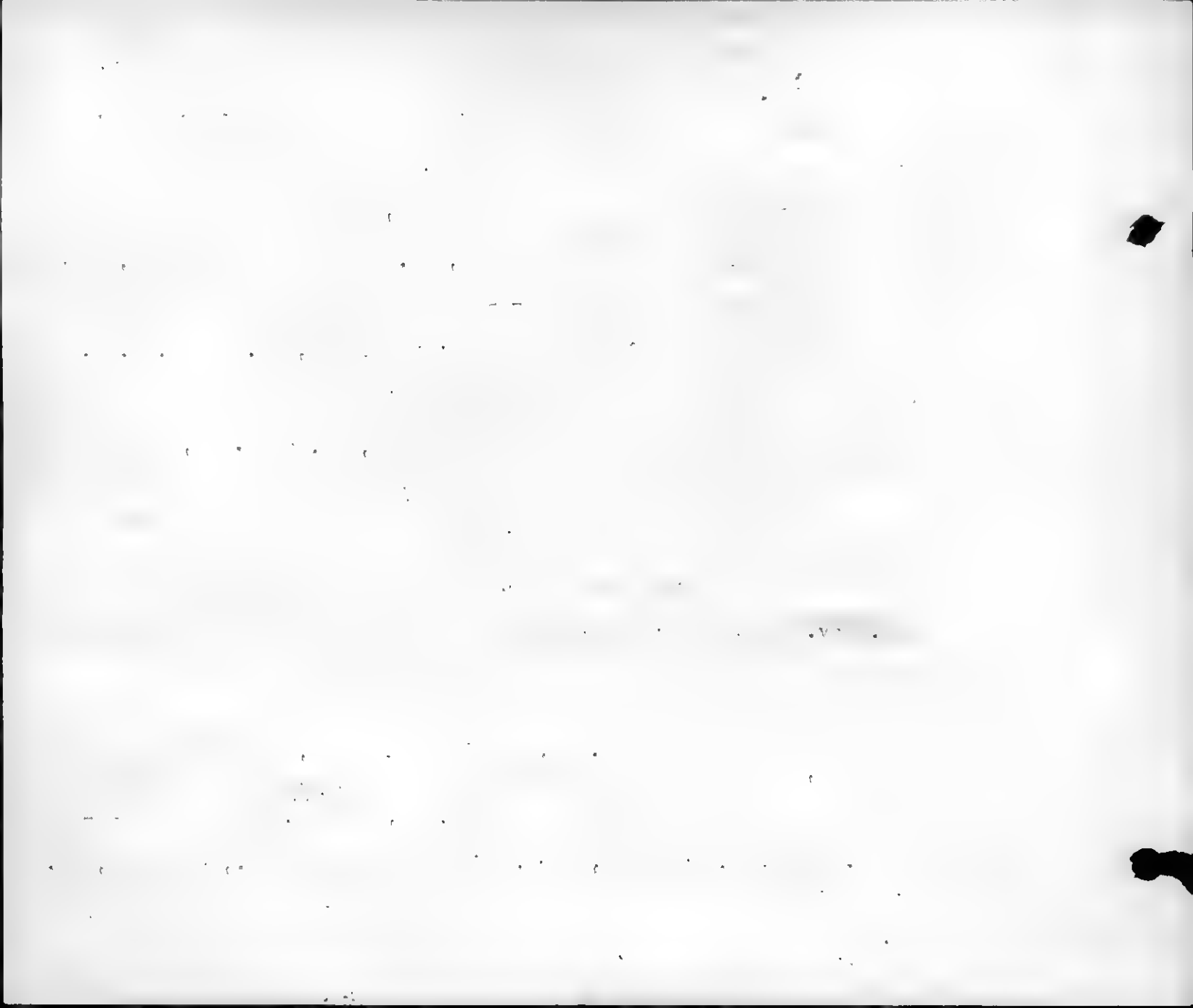
# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN TB <b>440 days</b>		12. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month Day Year <b>April 6, 1960</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-2-1877</b>		9. AGE (In years last birthday) yrs. <b>82</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Calvert County, Md.</b>	
13. FATHER'S NAME <b>John Kent</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Rice</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Thomas McKeever, Sr. - Rt. #3, Box 278</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> <b>420.1</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Myocardial infarction</b> DUE TO (c) <b>Arteriosclerosis</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mod. Adv. pulmonary tuberculosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Jan. 22, 1959</b> , to <b>April 6, 1960</b> , that I last saw the deceased alive on <b>April 6, 1960</b> , and that death occurred at <b>3:40 AM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Edgars M. Maculans MD</b>		M.D.		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>		DATE SIGNED <b>4-6-60</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt. Henryton State Hosp., Henryton, Md.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Apr. 11 1960 Annapolis</b>		22b. DATE THEREOF <b>Apr. 11 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Assenit</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. A. Johnson</b>		ADDRESS <b>Annapolis</b>		24a. REC'D BY REGISTRAR DATE <b>APR 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. Jones</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician.

VS AIS (4)  
15M 9/5B



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4419 Item 11, CERTIFICATE OF DEATH Film G260 4/11/60lb 4365

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>5 mo.-17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson #4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>Pot Spring Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Margaret</u> Last <u>KILROY</u>				4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-77</u>		9. AGE (In years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Clinton, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Kilroy</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Norton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Right Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c): <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>week</u> <u>  </u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CNS associated with cerebral arteriosclerosis with psychotic reaction.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/27/60</u> to <u>4/1/60</u> that (I) (we) last saw the deceased alive on <u>4/1/60</u> and that death occurred at <u>7:10 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Augustin del Campo, M.D.</u>				22b. PHYSICIAN'S NAME (Type) <u>Augustin del Campo, M.D.</u>		22c. DATE SIGNED <u>4/2/60</u>	
22d. ADDRESS <u>Springfield State Hospital</u>				22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION OR MOVALS (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/4/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City, town, or county) (State) <u>Old Field Rd Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clustin B. Donovan</u>				24a. ADDRESS <u>3818 Roland Ave</u>		25a. REC'D BY REGISTRAR DATE <u>APR 5 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

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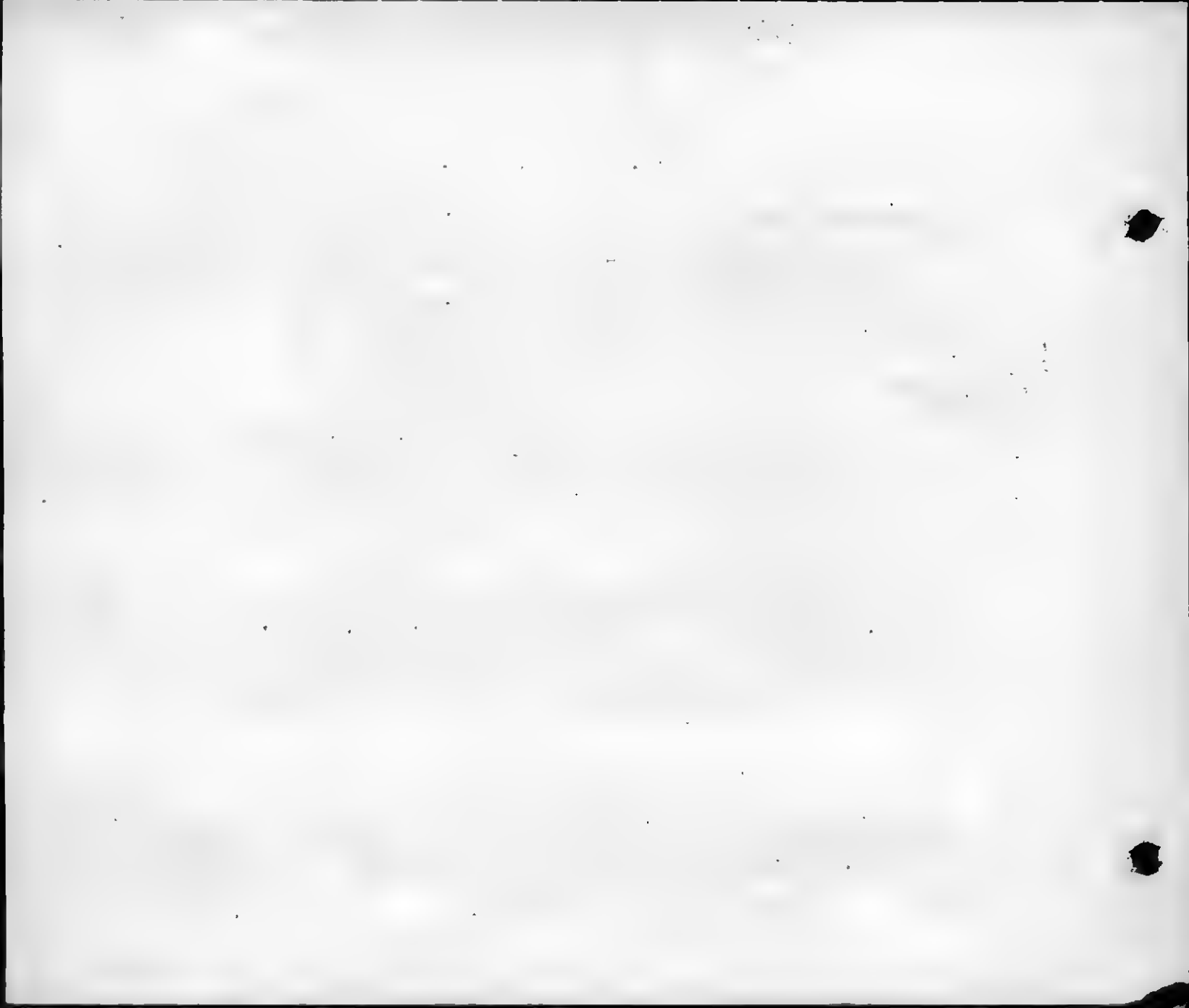
4420

64366

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3114</b>	
c. LENGTH OF STAY IN 1b <b>32yrs.3mos.11da.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>309 S. Bouldin Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>F. E.</b> Last <b>LABATUE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1st</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1908</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Eugene F. Labatue</b>		14. MOTHER'S MAIDEN NAME <b>Julia Ann Cassidy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records of Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>491X Confluent bronchopneumonia</b> DUE TO (b) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>---</b> INTERVAL BETWEEN ONSET AND DEATH <b>about 1 wk.</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with convulsive disorder with psychotic reaction; mental deficiency</b>			
19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>---</b> a. m. <b>---</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 21</b> 19 <b>27</b> , to <b>April 1</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>April 1</b> , 19 <b>60</b> , and that death occurred at <b>6:05A</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ellis S. Margolin</b>		22b. DATE SIGNED <b>4-1-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ellis S. Margolin</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-4-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Miller</b>		25a. REC'D. BY REGISTRAR <b>4/1/60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		25c. ADDRESS <b>2431 E. Oliver St.</b>	

APR 5 '60



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4421

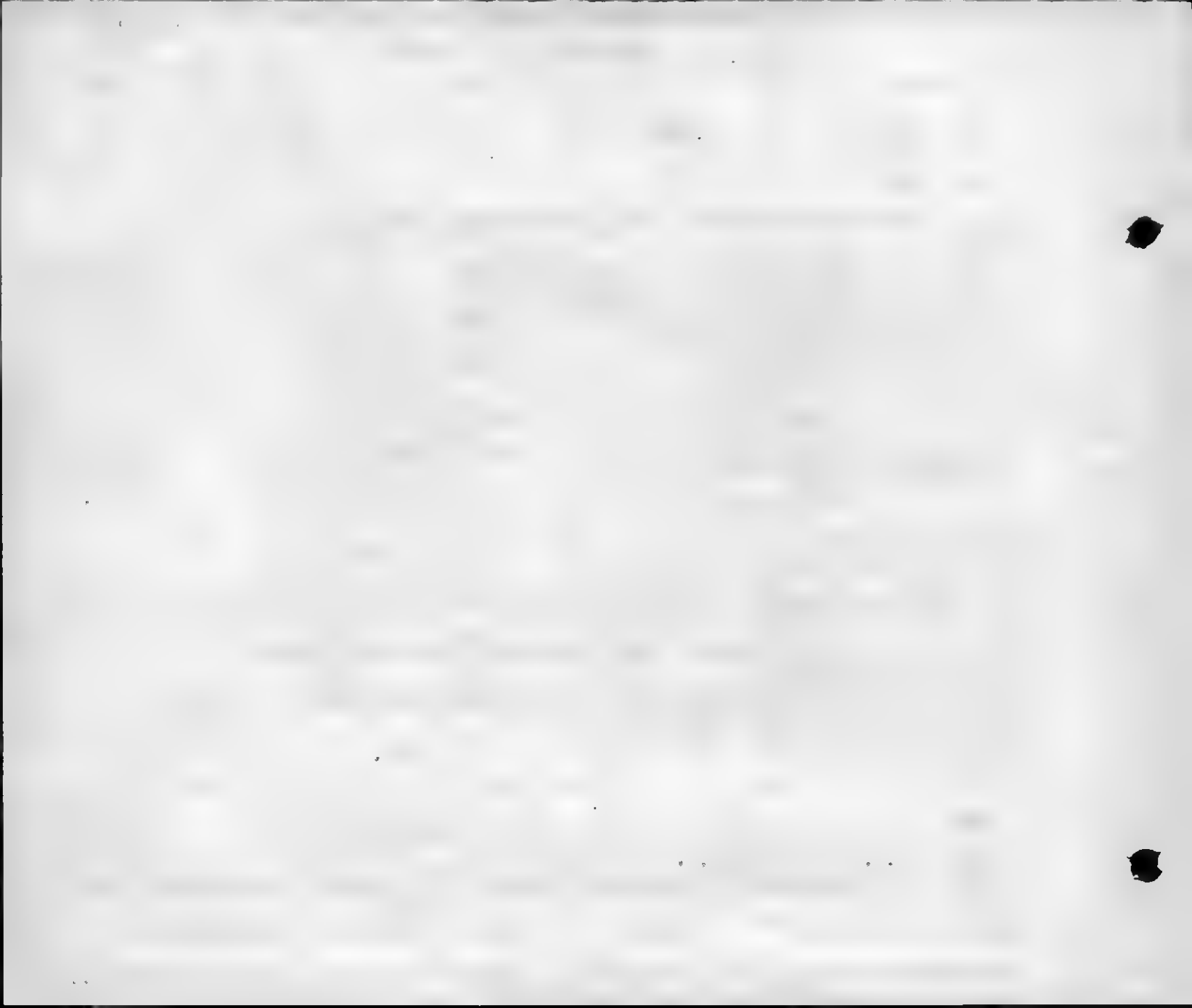
## CERTIFICATE OF DEATH

64367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers R.O.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <u>Millers R.O.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Mary Billie May Hippy</u>		4. DATE OF DEATH <u>April 27 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/14/1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed actor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Miss</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David R. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mandella Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-0629</u>	
17. INFORMANT <u>Mrs William Myers Miller</u>		Address <u>Millers Rd R.O.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>153.8</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1959</u> , to <u>April 27 1960</u> , that I last saw the deceased alive on <u>April 26 1960</u> , and that death occurred at <u>10 30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		DATE SIGNED <u>4/27/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/30/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manchesters</u>	22d. LOCATION (City, town, or county) (State) <u>Manchesters Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Becker</u>		24. REC'D BY REGISTRAR <u>May 2 '60</u>	
ADDRESS <u>Manchesters</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Henshaw</u>	

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4422 CERTIFICATE OF DEATH

64368

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>8 days</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Helen</b> Last <b>Schaffer</b> <b>LITTLE</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1960</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1894</b>			
9. AGE (In years last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min <b>66</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>					
13. FATHER'S NAME <b>Albert Schaffer</b>				14. MOTHER'S MAIDEN NAME <b>Mary V. Feeser</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>491X</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychotic depressive reaction with manic depressive reaction.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Springfield Hospital, Sykesville, Md.</b>				20g. (County) <b>Carroll</b>		20h. (State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1960</b> to <b>April 26, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 26, 1960</b> , and that death occurred at <b>8:30 AM</b> from the causes and on the date stated above									
22a. SIGNATURE <b>Julian Radcykowycz, M.D.</b>				22b. DATE SIGNED <b>4/26/60</b>					
22c. PHYSICIAN'S NAME (Type) <b>Julian Radcykowycz, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/29/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frederick Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rural, Westminster, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. S. Meyer Jr., Westminster, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 29 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

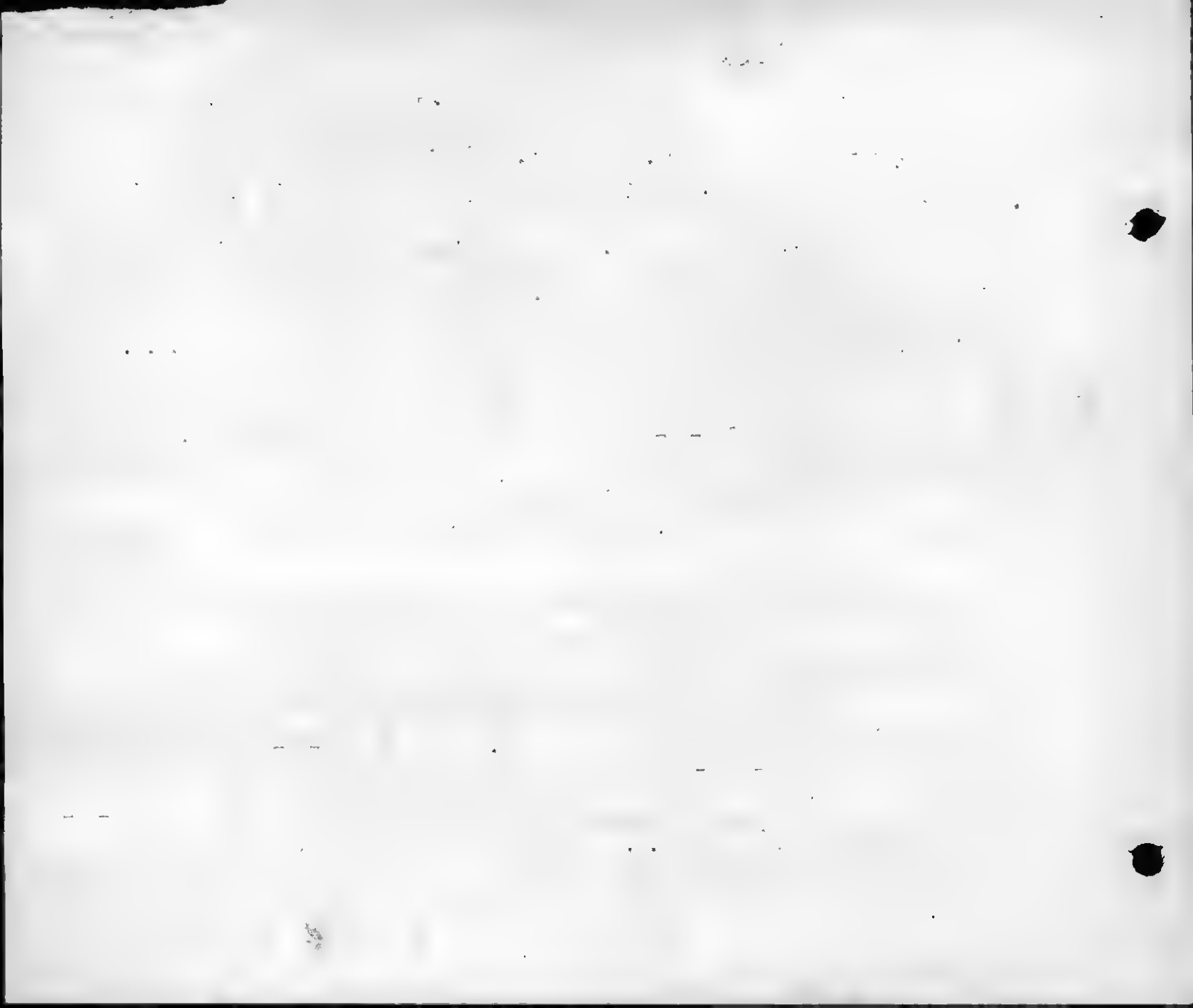
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>5 yrs. and 5 months</b> <b>Sykesville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>at his residence grounds of Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edmund</b> Middle <b>B.</b> Last <b>Lusthaus</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 2 -1899</b>		9. AGE (In years last birthday) <b>60</b> yrs	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutional Physician</b>			10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Be rnard</b>				14. MOTHER'S MAIDEN NAME <b>Anna</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>118-26-7674</b>		17. INFORMANT <b>Family</b> Address <b>Sykesville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH minutes
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b>							years
420.0 DUE TO <b>Arteriosclerotic Heart Disease</b> (b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1955</b> to <b>4-20-1960</b> that (I) (we) last saw the deceased alive on <b>4-18-1960</b> , and that death occurred at <b>12:35</b> M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>4-20-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b>				22d. ADDRESS <b>Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-21-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Abnazar Chased</b>		23d. LOCATION (City, town, or county) (State) <b>Randallstown Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LOCK EWIN JR 2100 Eutaw Place</b>				25a. REC'D BY REGISTRAR DATE <b>APR 21 '60</b>		25b. REGISTRAR'S SIGNATURE <b></b>	

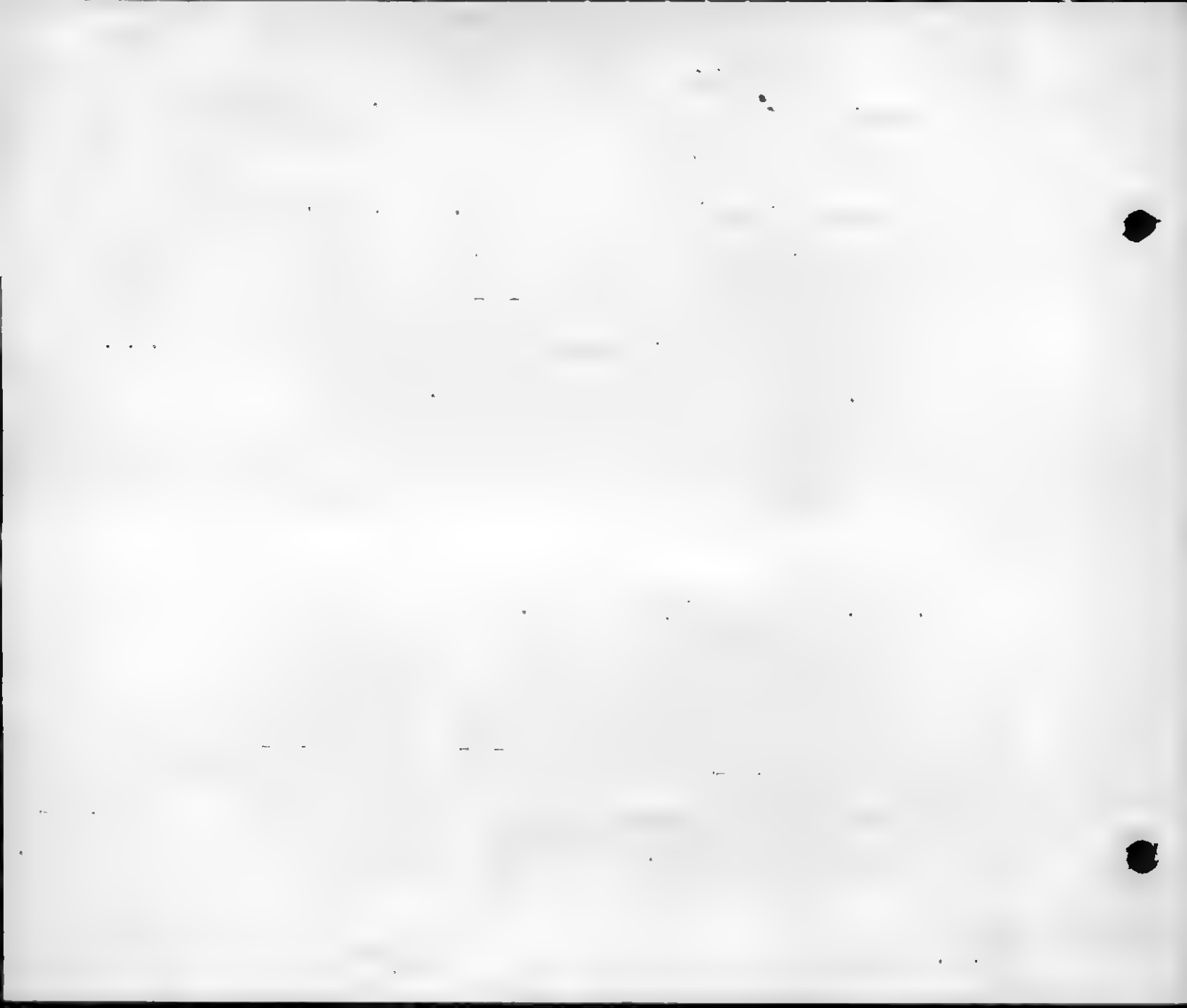




**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**4424** **CERTIFICATE OF DEATH** **64379**

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>2 mo 29 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>120 E. Patrick Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Miriam</b> Middle <b>Ruth</b> Last <b>Marcks</b>				4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>19 60</b>			
5 SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>5-17-05</b>		9 AGE (In years last birthday) <b>54</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles C. Lark</b>				14. MOTHER'S MAIDEN NAME <b>Lucy C. Hamilton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unkn</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Presenile sclerosis (Atrophy)</b> <b>305X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATING TO TERMINAL ILLNESS, LISTED IN PART I (a) <b>DBS. assoc. with cerebral arteriosclerosis without qualifying phrase Parkinsonism, Cortical blindness</b>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>1-18-</b> <b>19 60</b> to <b>4-16-</b> <b>19 60</b> , that (I) (we) last saw the deceased alive on <b>4-16-60</b> <b>19</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Edmund Lusthaus</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4-16-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>				22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/19/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. REGISTRAR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>APR 21 '60</b>		25b. REGISTRAR'S SIGNATURE <i>W. L. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. Page 2 of 2. Page 3 of 2. Page 4 of 2. Page 5 of 2. Page 6 of 2. Page 7 of 2. Page 8 of 2. Page 9 of 2. Page 10 of 2. Page 11 of 2. Page 12 of 2. Page 13 of 2. Page 14 of 2. Page 15 of 2. Page 16 of 2. Page 17 of 2. Page 18 of 2. Page 19 of 2. Page 20 of 2. Page 21 of 2. Page 22 of 2. Page 23 of 2. Page 24 of 2. Page 25 of 2. Page 26 of 2. Page 27 of 2. Page 28 of 2. Page 29 of 2. Page 30 of 2. Page 31 of 2. Page 32 of 2. Page 33 of 2. Page 34 of 2. Page 35 of 2. Page 36 of 2. Page 37 of 2. Page 38 of 2. Page 39 of 2. Page 40 of 2. Page 41 of 2. Page 42 of 2. Page 43 of 2. Page 44 of 2. Page 45 of 2. Page 46 of 2. Page 47 of 2. Page 48 of 2. Page 49 of 2. Page 50 of 2. Page 51 of 2. Page 52 of 2. Page 53 of 2. Page 54 of 2. Page 55 of 2. Page 56 of 2. Page 57 of 2. Page 58 of 2. Page 59 of 2. Page 60 of 2. Page 61 of 2. Page 62 of 2. Page 63 of 2. 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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

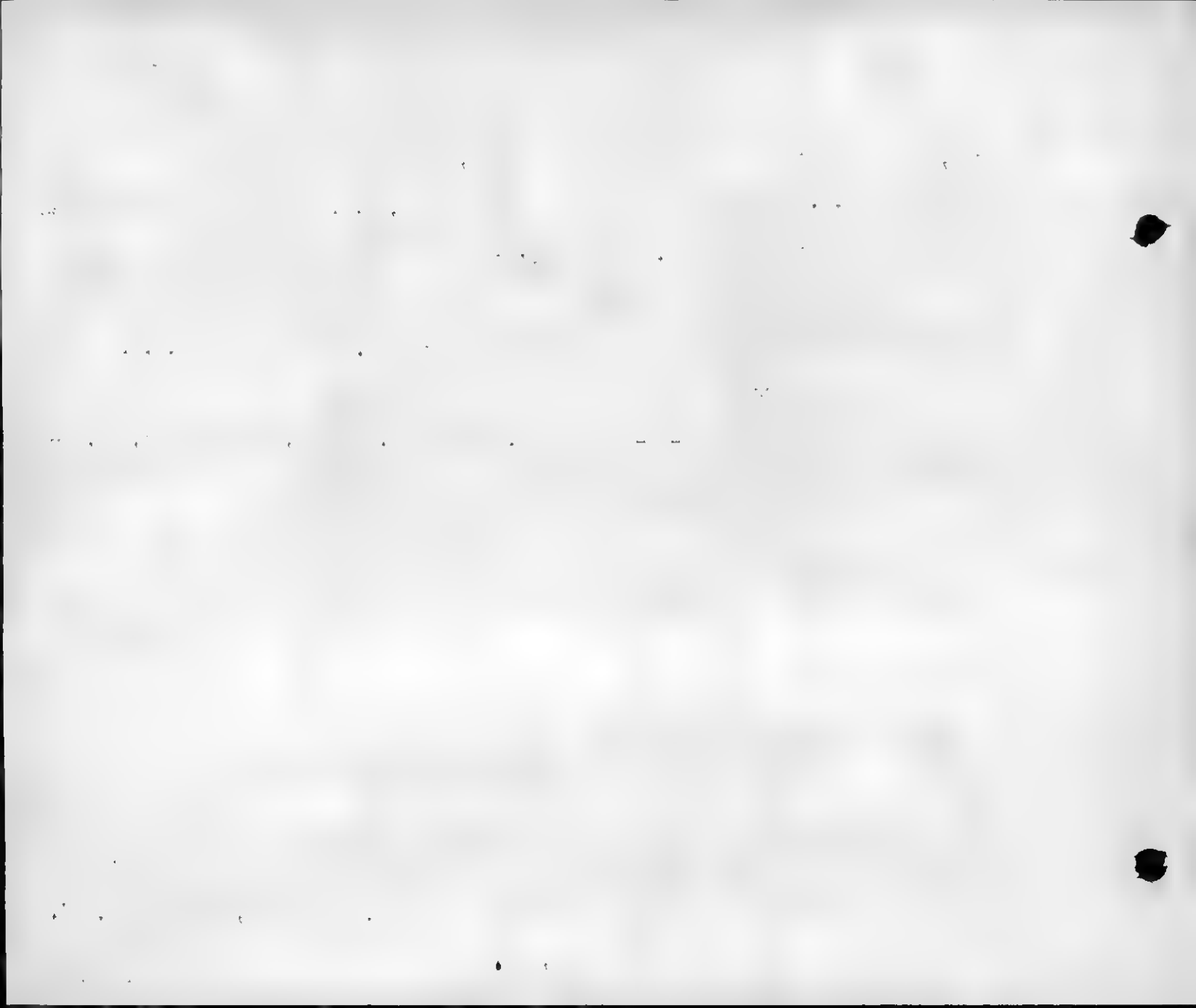
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1864372

4426

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Westminster, R.D.2 (Union Mills)</b>		/d. STREET ADDRESS <b>Westminster, R.D.2 (Union Mills)</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>H.</b> Last <b>Meyers</b>		4. DATE OF DEATH Month <b>4</b> Day <b>7</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
13. FATHER'S NAME <b>William Henry Meyers</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hudson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-32-4304</b>	17. INFORMANT Address <b>Mrs. William H. Meyers, Westminster, Md. R-2</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Minute</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James J. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/9/60 Burial</b>		22b. DATE THEREOF <b>4/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baust Church Cemetery</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		ADDRESS <b>Littlestown, Pa.</b>	
24a. REC'D BY REGISTRAR <b>APR 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

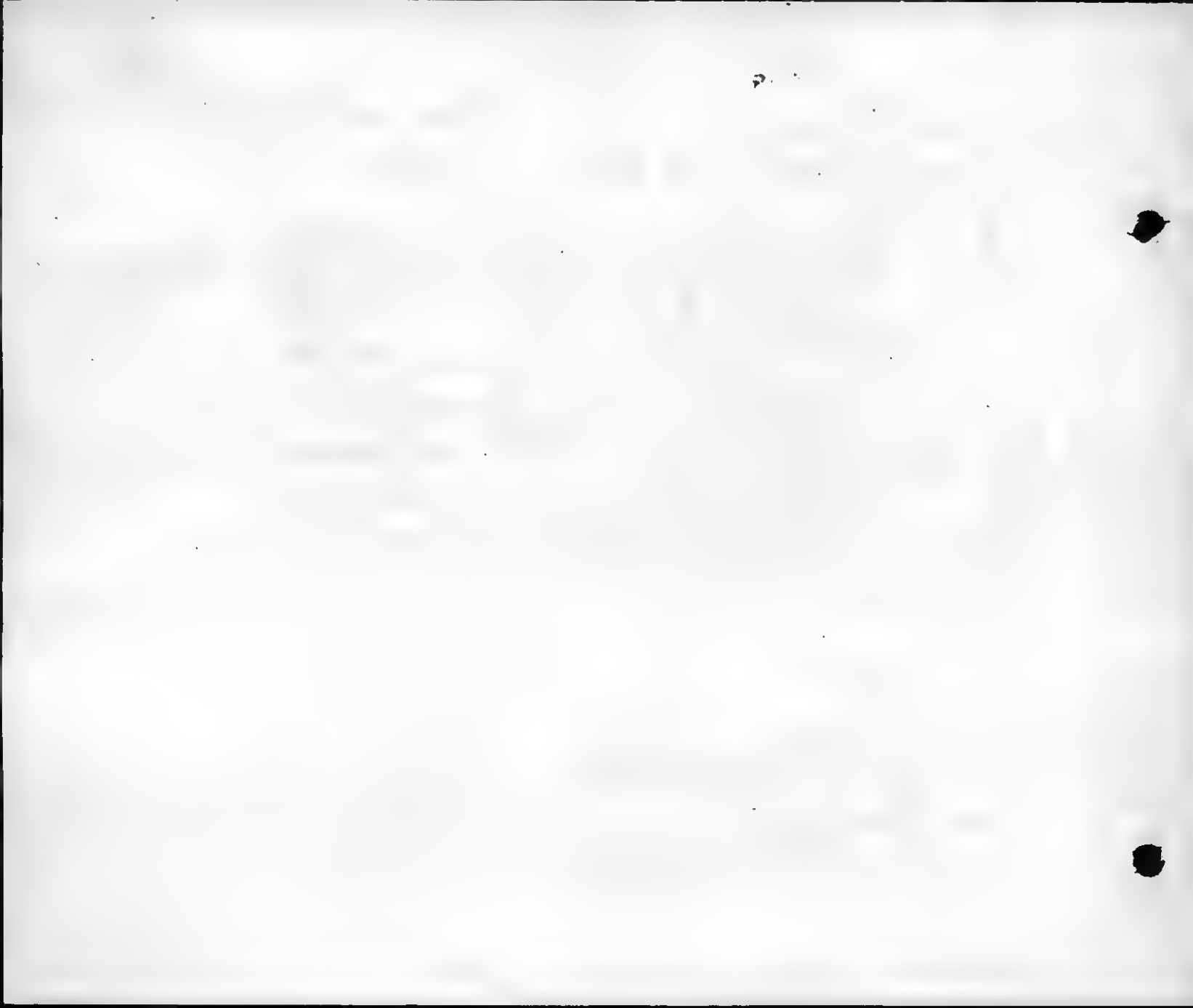
4427

## CERTIFICATE OF DEATH

Reg. Dist. No. 4373

1. PLACE OF DEATH a. COUNTY <u>Barnall</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barnall</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA - M - NAYLOR</u>		4. DATE OF DEATH Month Day Year <u>April 30 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 27 - 1867</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Elisha Myers</u>		14. MOTHER'S MAIDEN NAME <u>Harvey Myerman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Thos. Tawney</u> Address <u>Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 15</u> 19 <u>48</u> to <u>April 30</u> 19 <u>60</u> that I last saw the deceased alive on <u>April 29</u> 19 <u>60</u> and that death occurred at <u>9 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		DATE SIGNED <u>5/4/60</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>Hampstead Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial May 3-60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Freestone Lutheran Burial Co Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. E. Tipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 4 60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



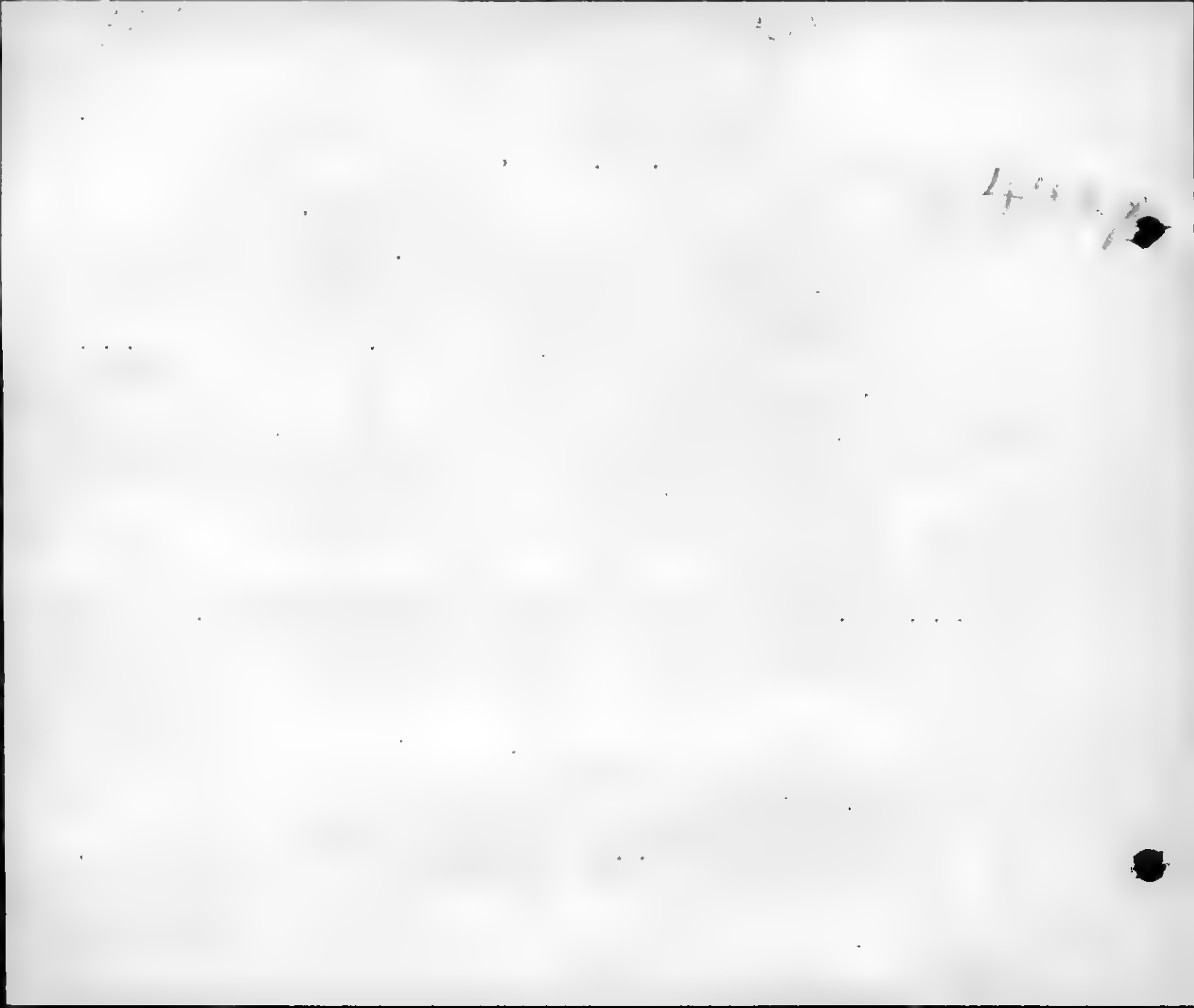


TO HOW OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4428 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64374

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City-Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4yrs.5mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2125 Maryland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alonzo</b> Middle <b>Hall</b> Last <b>Nichols, Sr.</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 3, 1874</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min <b>85</b>		IF UNDER 24 HRS. Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min <b>85</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>House Painter</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles G. Nichols</b>				14. MOTHER'S MAIDEN NAME <b>Elsa Nesworth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>				16. SOCIAL SECURITY NO <b>- 3</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Lays</b> <b>Years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 14, 1955</b> to <b>April 13, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 13, 1960</b> , and that death occurred at <b>AP.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Agustin del Campo.</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/13/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-15-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Freedom</b>		23d. LOCATION (City, town, or county) (State) <b>Elkensburg Carroll Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight - Sykesville, Md.</b>				ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4392

## CERTIFICATE OF DEATH

Reg. Dist. No.

4375

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>53 E. MAIN STREET</b>		e. STREET ADDRESS <b>53 E. MAIN STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>ELIZABETH W.</b> Last <b>NULL</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25 1906</b>
9. AGE (In years last birthday) <b>53</b> yrs		10. IF UNDER 1 YEAR: Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Laurel, Prince</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Harvey S. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Emma Crawford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-36 9364</b>	
17. INFORMANT <b>Lois H. Null, Westminister, Md.</b>		Address <b>53 E. Main St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 HOURS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 14, 1960</b> , to <b>APRIL 14, 1960</b> , that I last saw the deceased alive on <b>APRIL 14, 1960</b> , and that death occurred at <b>11:20 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel I. Welliver</b> M.D.		ADDRESS (Street, city or town, state) <b>19 RIDGE ROAD</b> DATE SIGNED <b>4/14/60</b>	
PHYSICIAN'S NAME (Type) <b>DANIEL I. WELLIVER</b>		<b>WESTMINSTER MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>4/18/60</b>	<b>Bonnet Cemetery</b>	<b>Westminister, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. S. Meyer, Jr., Westminister, Md.</b>		24. REC'D BY REGISTRAR <b>DATE APR 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

432.1

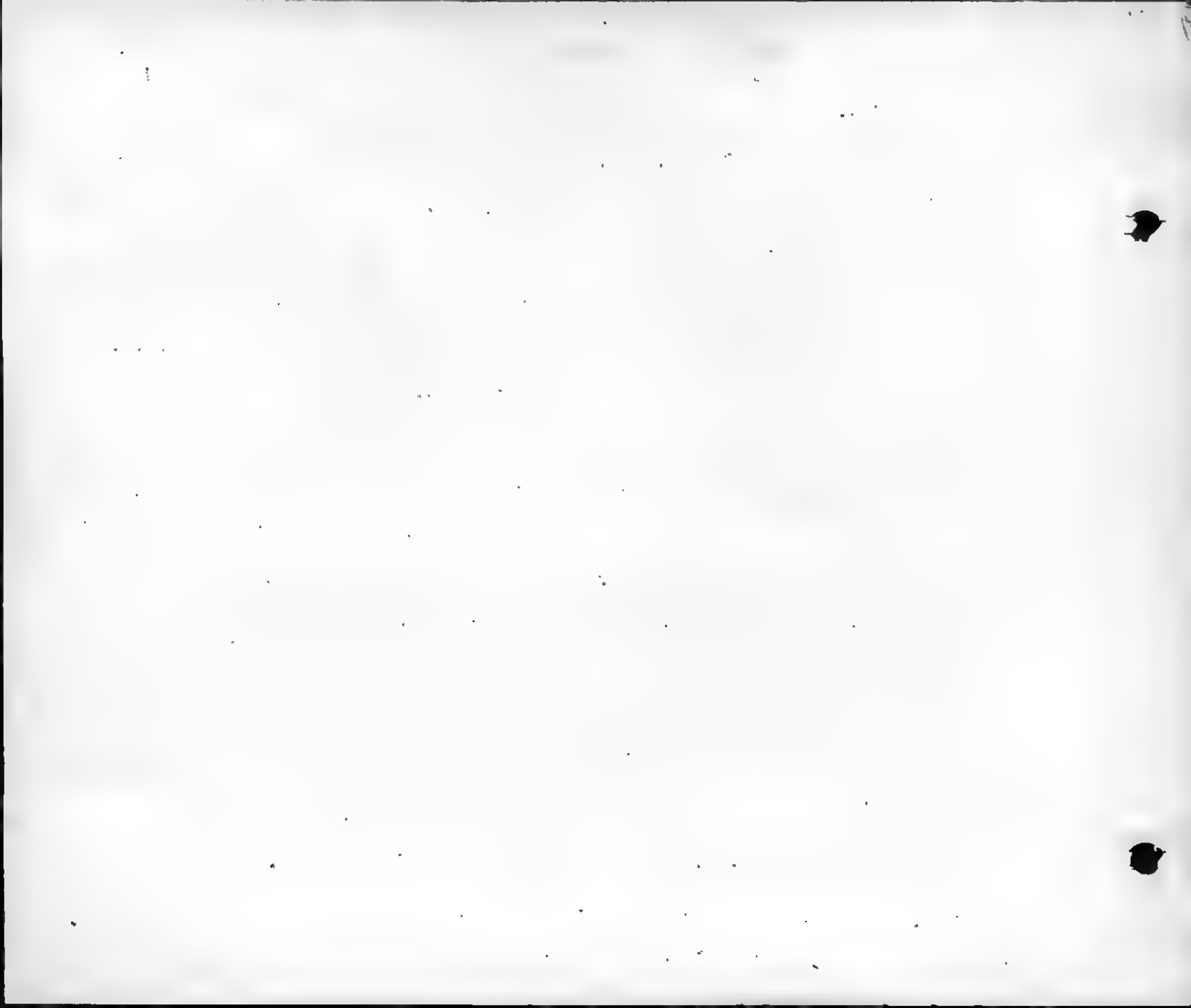
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4429** **CERTIFICATE OF DEATH** **64376**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> <b>22 days</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>10309 Armory Road</u>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Elbert Dice Plummer</u>			<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>13</u> Year <u>1960</u>												
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>											
<b>8. DATE OF BIRTH</b> <u>March 30, 1876</u>		<b>9. AGE</b> (In years last birthday) <u>84</u> yrs <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>0</u></td> <td><u>13</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min.	<u>0</u>	<u>13</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS													
Months	Days	Hours	Min.												
<u>0</u>	<u>13</u>														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>											
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>															
<b>13. FATHER'S NAME</b> <u>Robert Plummer</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Eliza Petticord</u>												
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>218-30-1333</u>		<b>17. INFORMANT</b> <u>Springfield Hospital Records</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b>  <u>Arteriosclerotic heart disease</u>            DUE TO         </td> <td rowspan="3"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>Years</u> </td> </tr> <tr> <td colspan="2"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>            (b) <u>Coronary arteriosclerosis</u>            DUE TO         </td> </tr> <tr> <td colspan="2">           (c)         </td> </tr> <tr> <td colspan="3"> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  <u>C.B.S. associated with cerebral arteriosclerosis with psychotic reaction</u> </td> <td> <b>19. WAS AUTOPSY PERFORMED?</b>            YES <input type="checkbox"/> NO <input type="checkbox"/> </td> </tr> </table>					<b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <u>Arteriosclerotic heart disease</u> DUE TO		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Years</u>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> (b) <u>Coronary arteriosclerosis</u> DUE TO		(c)		<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>C.B.S. associated with cerebral arteriosclerosis with psychotic reaction</u>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <u>Arteriosclerotic heart disease</u> DUE TO		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Years</u>													
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> (b) <u>Coronary arteriosclerosis</u> DUE TO															
(c)															
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>C.B.S. associated with cerebral arteriosclerosis with psychotic reaction</u>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>												
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 21, 1960</u> <b>to</b> <u>April 13, 1960</u> <b>that (I) (we) last saw the deceased alive on</b> <u>April 13, 1960</u> <b>and that death occurred at</b> <u>10:20PM</u> <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Agustin del Campo</u> M.D.				<b>22b. DATE</b> <u>4/14/60</u>											
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Agustin del Campo, M.D.</u>				<b>22d. ADDRESS</b> <u>Springfield Hospital, Sykesville, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4/16/60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Goshen Cemetery</u>											
<b>23d. LOCATION</b> (City, town, or county) (State) <u>Goshen, Maryland</u>															
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>			<b>ADDRESS</b> <u>Bethesda, Maryland</u>												
<b>25a. REC'D BY REGISTRAR</b> DATE <u>APR 19 '60</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.









TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be completed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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4431

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64378

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparksville</u>				c. LENGTH OF STAY IN 1b <u>One Month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>R.T. # 5</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Elizabeth Hartle Robison</u>				4. DATE OF DEATH Month Day Year <u>4 15 1960</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-72</u>		9. AGE (In years last birthday) <u>87</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13 FATHER'S NAME <u>Samuel Hartle</u>				14 MOTHER'S MAIDEN NAME <u>Alice Creager</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address: <u>1601 Franklin St. Johnstown, PA.</u> Name: <u>Mrs. Goldie Clancy</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-vascular Cardiac Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic assoc. with senile brain disease, with psychotic reaction??</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-18-1960</u> to <u>4-15-1960</u> that (I) (we) last saw the deceased alive on <u>4-15-1960</u> , and that death occurred at <u>4:15 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Edmund Lusthaus</u> M.D.				22b. DATE SIGNED <u>4-15-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus, M.D.</u>				22d. ADDRESS <u>Springfield State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4/18/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harbaugh Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Rouzer ville, Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich - Greencastle, Pa.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

497x

4432

## CERTIFICATE OF DEATH

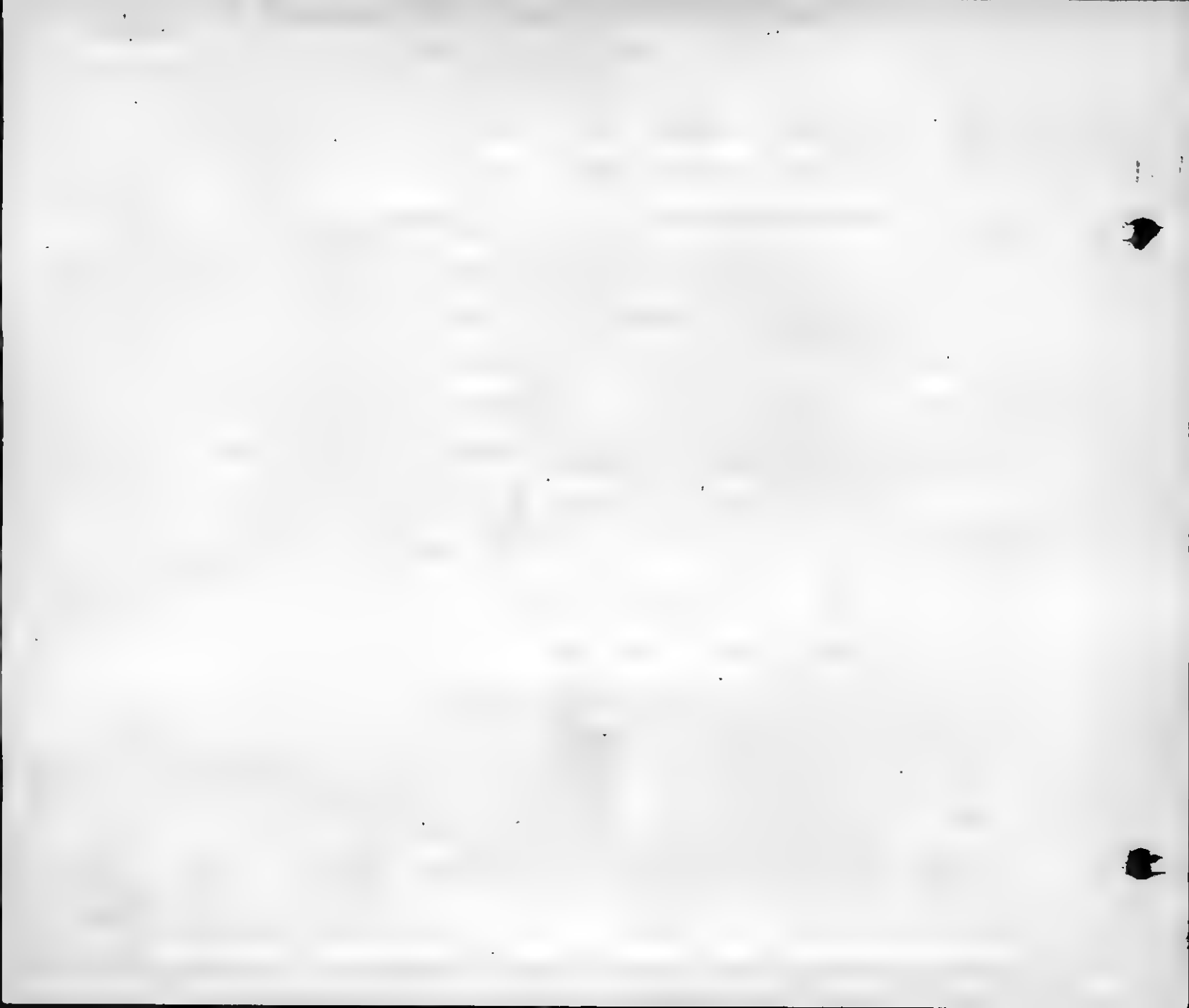
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HAMPSTEAD Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>21 GILL AVE</u>		d. STREET ADDRESS <u>21 GILL AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Benjamin Franklin Roop</u>		4. DATE OF DEATH Month Day Year <u>April 4 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 5 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Pierce Roop</u>		14. MOTHER'S MAIDEN NAME <u>Ira Sedonia Bond.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes.</u> (If yes, give war or dates of service) <u>WW. 1918-19 212-10-5136</u>		16. SOCIAL SECURITY NO. <u>212-10-5136</u>	
17. INFORMANT <u>Mrs Grace Roop - HAMPSTEAD Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor (middle fossa)</u> <u>2 2 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 7</u> , 19 <u>57</u> , to <u>April 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>60</u> , and that death occurred at <u>9:20 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Busch</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>4/4/60</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Busch MD</u>		<u>HAMPSTEAD Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>apr 7-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>	22d. LOCATION (City, town, or county) (State) <u>Small Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Hixton - Hampstead Md</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR <u>APR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4393

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13 RIDGE RD.</b>		d. STREET ADDRESS <b>13 RIDGE RD.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY ELIZABETH ROYER</b>		4. DATE OF DEATH Month Day Year <b>APRIL 13 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 19, 1891</b>
9. AGE (In years last birthday) yrs. Months Days Hours Min <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN T. ROYER</b>	
14. MOTHER'S MAIDEN NAME <b>ANNA M. WEYBRIGHT</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>EDGAR ROYER 13 RIDGE RD WESTMINSTER</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF OVARY WITH METASTASES</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>6 MOS</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>FEB. 4, 1960</b> , to <b>APRIL 13, 1960</b> , that I last saw the deceased alive on <b>APRIL 12, 1960</b> , and that death occurred at <b>11:40 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William J. Stewart</b> , M.D.		ADDRESS (Street, city or town, state) <b>19 RIDGE RD.</b> DATE SIGNED <b>4/13/60</b>	
PHYSICIAN'S NAME (Type) <b>WESTMINSTER, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>4/16/60</b>	<b>Methodist Episcopal Church, Westminister, Md</b>	<b>Westminister, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>* S. 112 Westminister Rd</b>		24a. REC'D BY REGISTRAR <b>DATE APR 18 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

175.1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64381

4394

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a death is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>234 1/2 E. Main St.</u>				e. STREET ADDRESS <u>234 1/2 E. Main St.</u>			
3. NAME OF DECEASED (Type or print) <u>LILLIAN MAE SCHLERF</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20, 1883</u>		9. AGE (In years and birth day) <u>77</u> yrs	10. UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	11. UNDER 24 HRS. Hours <u>7</u> Min. <u>0</u>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		13. KIND OF BUSINESS OR INDUSTRY <u>—</u>		14. BIRTHPLACE (State or foreign country) <u>Eastview Carroll Co. Md.</u>		15. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. FATHER'S NAME <u>Edward Osterhus</u>				17. MOTHER'S MAIDEN NAME <u>Elizabeth Logue</u>			
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		19. SOCIAL SECURITY NO. <u>—</u>		20. INFORMANT <u>Mr. Fred L. Schlerf, same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>							
DUE TO (b) <u>IX</u>							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type or print) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4/28/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery, Westminster, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr., Westminster, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	





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64382

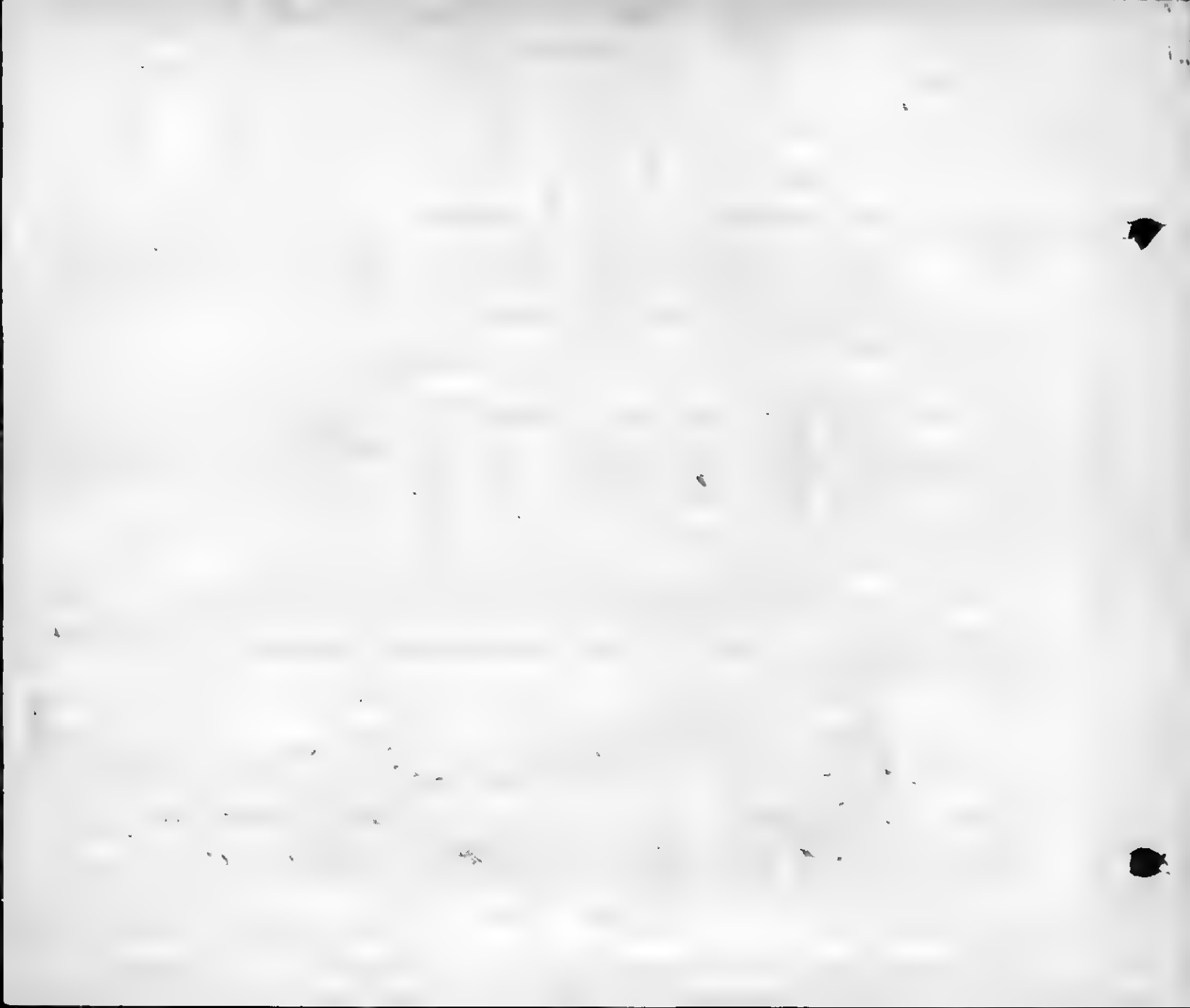
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sullivan Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER LEWIS SHETTLE</u>		4. DATE OF DEATH Month Day Year <u>April 2 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23, 1899</u>
9. AGE (in years last birthday) <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	
11. BIRTHPLACE (State or foreign country) <u>Black &amp; Decker Westminster Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Christopher Shettle</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Meyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>218-32-4342</u>	
17. INFORMANT <u>Mrs. L. Shettle</u>		Address <u>Westminster Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12:35</u> , 19 <u>4-2-60</u> , to <u>4-2-60</u> , that I last saw the deceased alive on <u>4-1-60</u> , 19 <u>60</u> , and that death occurred at <u>6:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. C. Jannette</u> M.D. <u>103 E Main Westminster Md</u>		DATE SIGNED <u>4-4-60</u>	
PRINTED NAME (Type) <u>Wm. C. Jannette</u>		ADDRESS (Street, city or town, state) <u>103 E Main Westminster Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cem. Pleasant Valley, Carroll Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. E. Meyer</u> ADDRESS <u>Westminster Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

MEDICAL CERTIFICATION

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



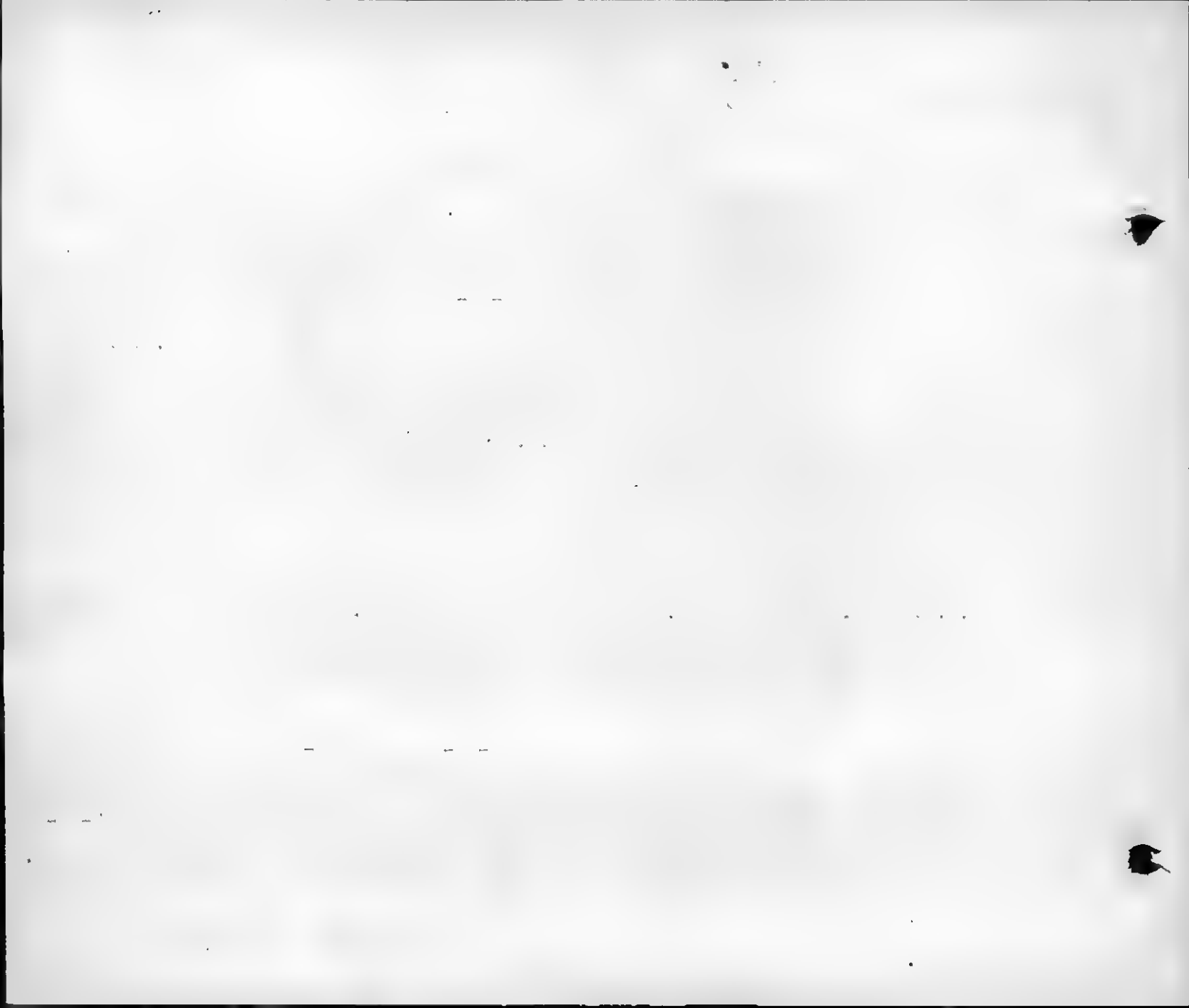
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

64383

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>4 mo 28 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>114 S. Smallwood Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Neva(Nevada)</b> Middle <b>Viola</b> Last <b>Shoup</b>		4. DATE OF DEATH Month <b>4</b> Day <b>17</b> Year <b>1960</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-10-79</b>
9. AGE (In years and birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR: Months <b>4</b> Days <b>17</b> Hours <b>19</b> Min <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Ruben Davis</b>		14 MOTHER'S MAIDEN NAME <b>Albina Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>S.S. Hospital Records</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>11-19-59</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>G.B.S. assoc. with cerebral arteriosclerosis with psych. reaction</b> <b>Decubitus ulcers</b>			INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>11-19-59</b> 19 <b>4-16-60</b> 19 <b>7: A</b> M, that (I) (we) last saw the deceased alive on <b>4-16-60</b> 19 <b>7: A</b> M, and that death occurred at <b>7: A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Edmund Lusthaus</b> 22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		22b. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b> 22d. DATE SIGNED <b>4-17-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/17/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		25a. REC'D BY REGISTRAR <b>APR 19 60</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64384

4435

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Skidmore</b>	
c. LENGTH OF STAY IN 1b <b>144 days</b>		d. STREET ADDRESS <b>Route 2, Box 385</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Perry</b> Middle <b>Adley</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-21-1897</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	11. BIRTHPLACE (State or foreign country) <b>Skidmore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			

13. FATHER'S NAME <b>Phillip Smith</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Hiseman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Perry A. Smith - patient</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular Deficiency</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Far Advanced Bilateral Pulmonary Tuberculosis, active</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

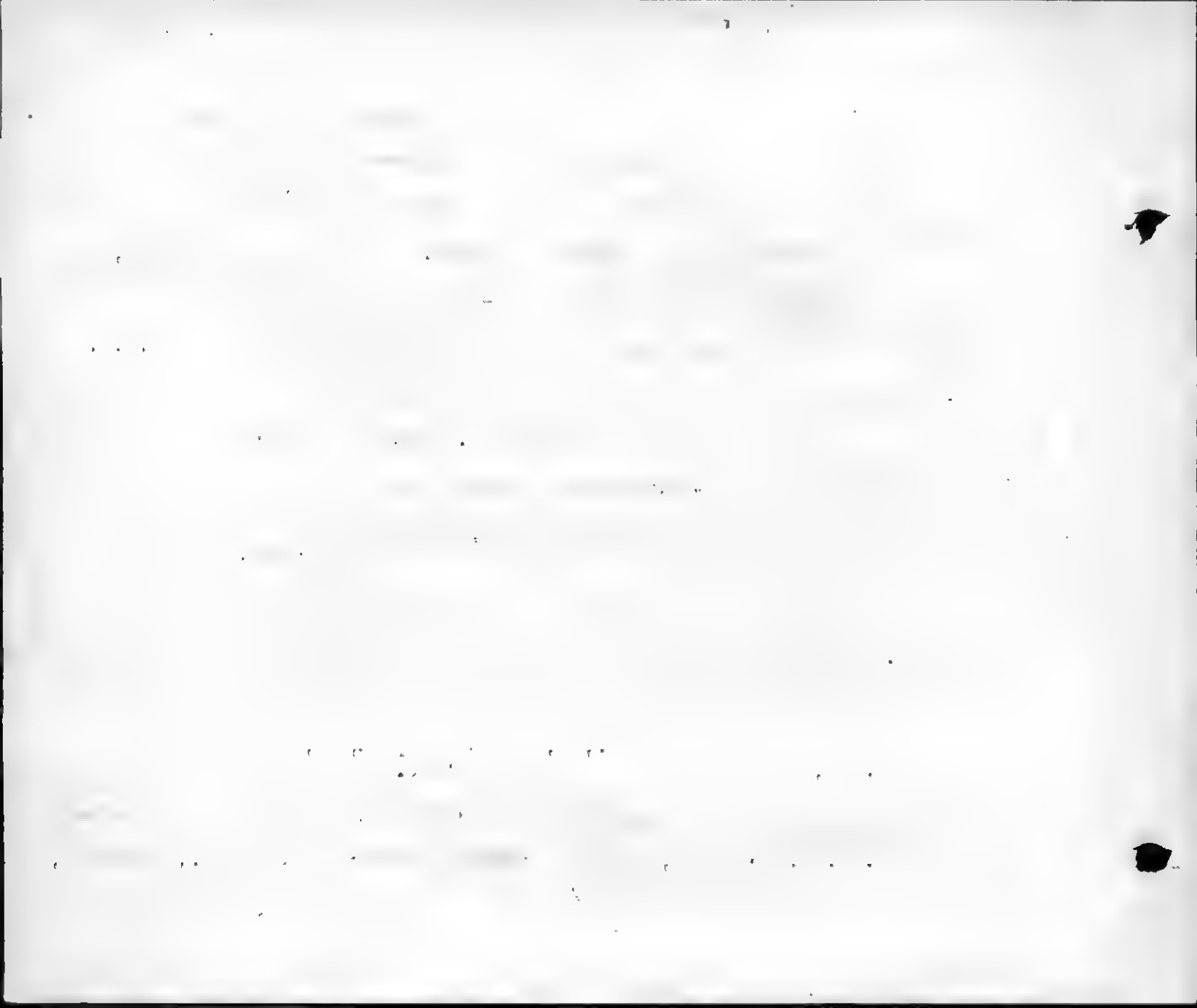
21. I certify that I attended the deceased from <b>Dec., 2, 1959</b> to <b>April, 24, 1960</b> that I last saw the deceased alive on <b>Apr., 24, 1960</b> and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>	DATE SIGNED <b>4-24-60</b>
ACTUAL SIGNATURE <b>E. M. Maculans M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. E. M. Maculans, Superintendent Henryton State Hosp., Henryton, Md.</b>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-28-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>	22d. LOCATION (City, town, or county) (State) <b>St. Marys A.A. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dr. E. M. Maculans</b>		24a. REC'D BY REGISTRAR <b>4-24-60</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

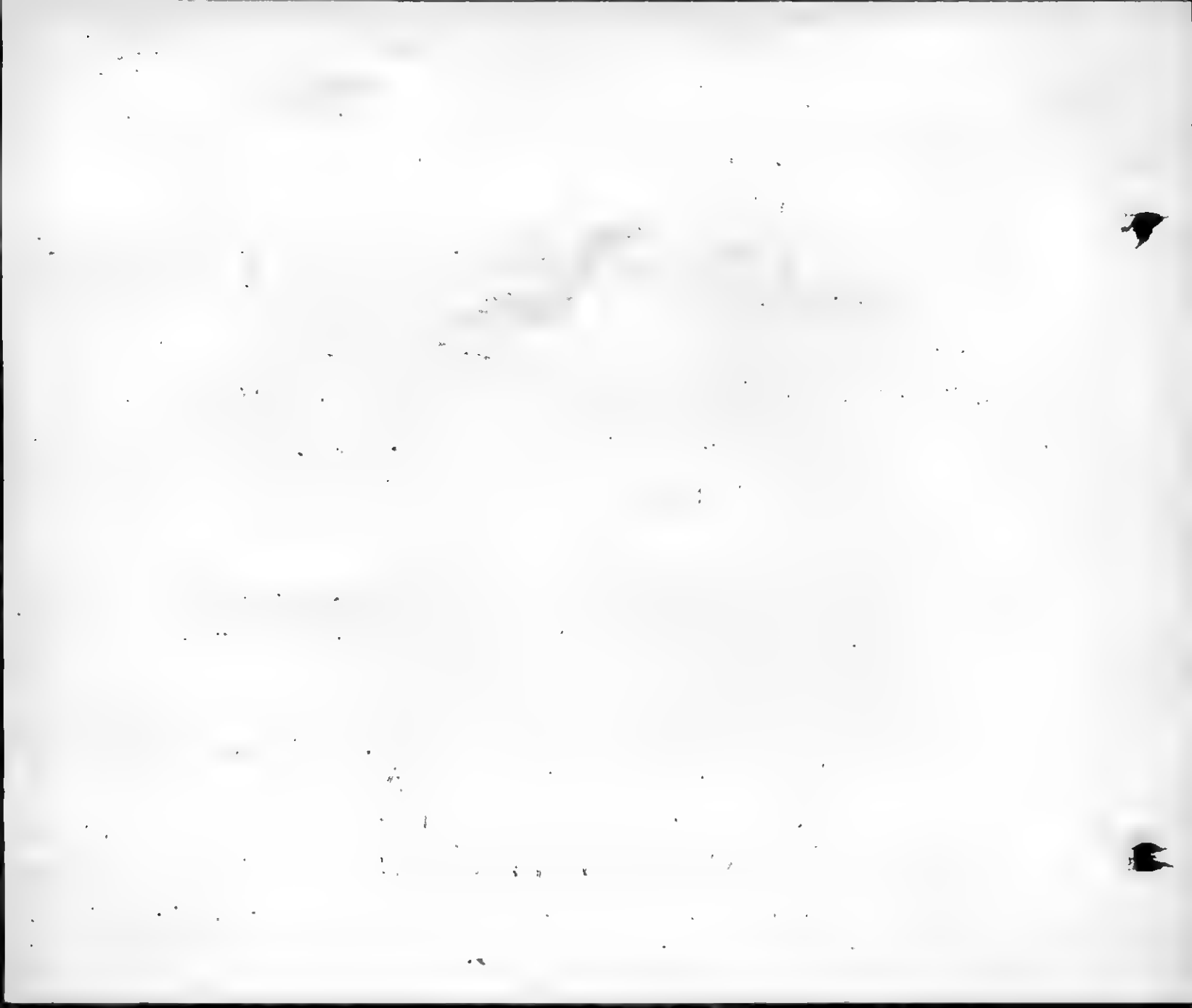
4436

## CERTIFICATE OF DEATH

64385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Straban Twp.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminister</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reese</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Naisy</u> Middle <u>Snead</u> Last <u>Snead</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Augusta Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jessie Bridger</u>		14. MOTHER'S MAIDEN NAME <u>Hiramie Lockbridge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-16-1504B</u>	
17. ADDRESS <u>Hinsford Road, Gettysburg, PA 17325</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE (a) <u>Cerebral softening with mental deterioration</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14, 1960</u> to <u>May 6, 1960</u> that I last saw the deceased alive on <u>April 14, 1960</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Reese Wilkens</u>		DATE SIGNED <u>5/6/60</u>	
PHYSICIAN'S NAME (Type) <u>DR. E. Reese Wilkens</u>		ADDRESS <u>Westminister Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/9/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Adam E. H. B. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminister Twp. Adams Co. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers</u>		ADDRESS <u>Westminister, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
DATE <u>MAY 9 '60</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4395

## CERTIFICATE OF DEATH

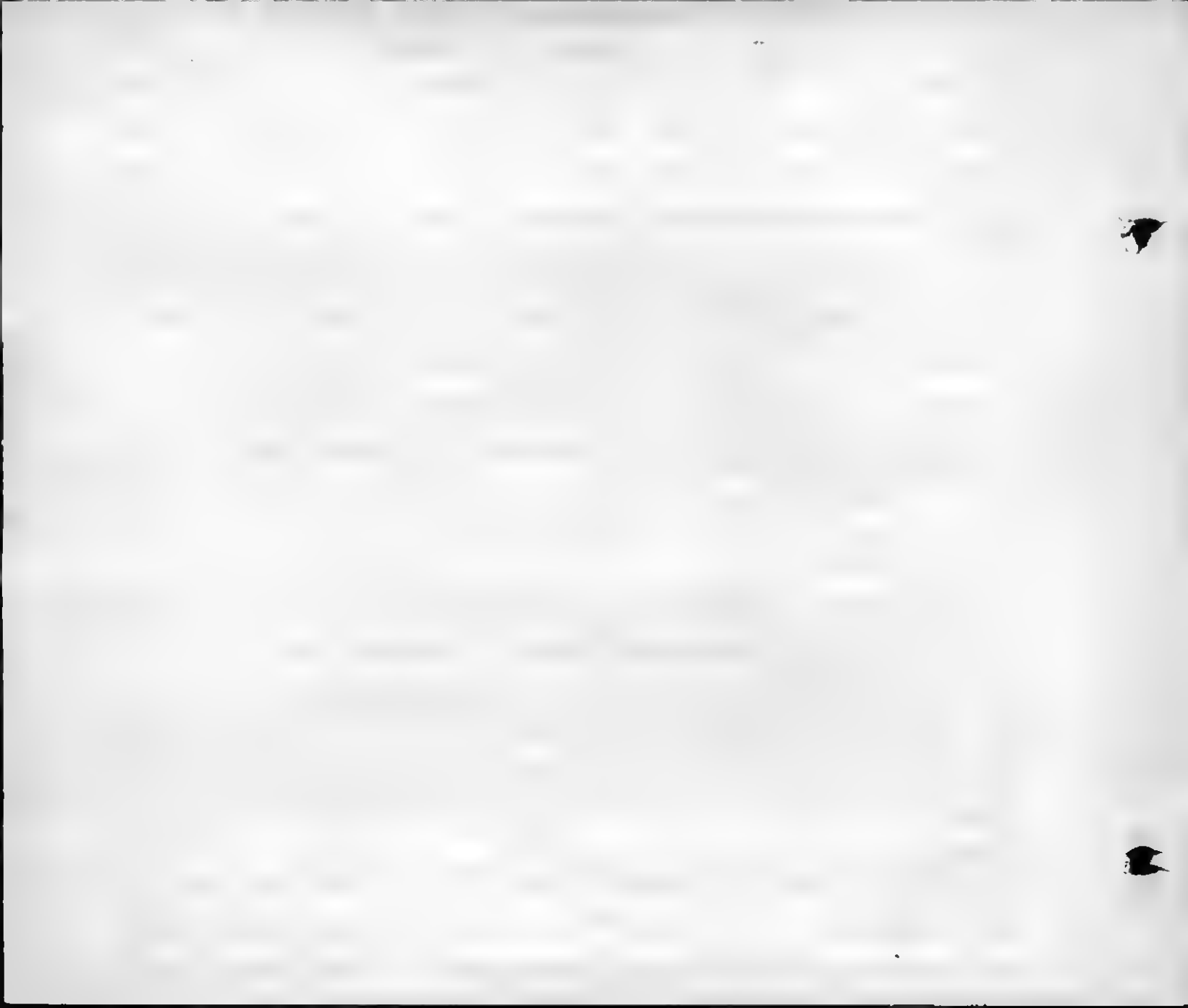
Reg. Dist. No.

64386

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5213 2nd St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>JONES</u> Last <u>STARR</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, from Westinghouse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Severn, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert C. Starr</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Miss H. J. Starr</u>		Address <u>5213 2nd St. Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON WITH METASTASES</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 20, 1959</u> , to <u>APRIL 16, 1960</u> , that I last saw the deceased alive on <u>APRIL 16, 1960</u> , and that death occurred at <u>10:10</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William S. Stewart</u> M.D.		ADDRESS (Street, city or town, state) <u>19 RIDGE RD</u> DATE SIGNED <u>4/16/60</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM S. STEWART</u>		<u>WESTMINSTER, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery, Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Stewart</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. S. Stewart</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Stewart</u>	
DATE <u>APR 21 '60</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 287

4396

1. PLACE OF DEATH a. COUNTY: <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: <u>Maryland</u> b. COUNTY: <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): <u>1877 Colonial Ave</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): <u>1877 Colonial Ave</u>			
c. LENGTH OF STAY IN 1b: <u>25412</u>				d. STREET ADDRESS: <u>1877 Colonial Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: <u>1877 Colonial Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print): <u>JOSEPH CLARENCE STOCKDALE</u>				4. DATE OF DEATH: <u>APRIL 2 1960</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH: <u>April 5 1894</u>	
9. AGE (In years last birthday) yrs: <u>65</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Frederick Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME: <u>Joseph B. Stockdale</u>		14. MOTHER'S MAIDEN NAME: <u>Laura H. Stockdale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): <u>—</u>		16. SOCIAL SECURITY NO.: <u>217-16 7666</u>		17. INFORMANT: <u>Wm. P. Stockdale</u> Address: <u>1877 Colonial Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>720.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH: <u>Several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY: Month, Day, Year Hour a. m. p. m. 19 <u>60</u>				20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 20, 1958</u> to <u>Apr 2, 1960</u> , that I last saw the deceased alive on <u>Apr 2, 1960</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE: <u>James S. Marsh</u> M.D.				ADDRESS (Street, city or town, state): <u>—</u> DATE SIGNED: <u>4/2/60</u>			
PHYSICIAN'S NAME (Type): <u>JAMES T. MARSH</u>				SIGNATURE: <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		22b. DATE THEREOF: <u>3/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY: <u>Frederick Cemetery</u>		22d. LOCATION (City, town, or county) (State): <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE: <u>—</u> ADDRESS: <u>—</u>				24a. REC'D BY REGISTRAR: <u>—</u> DATE: <u>APR 5 '60</u>		24b. REGISTRAR'S SIGNATURE: <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, on or before the event within 72 hours after death.

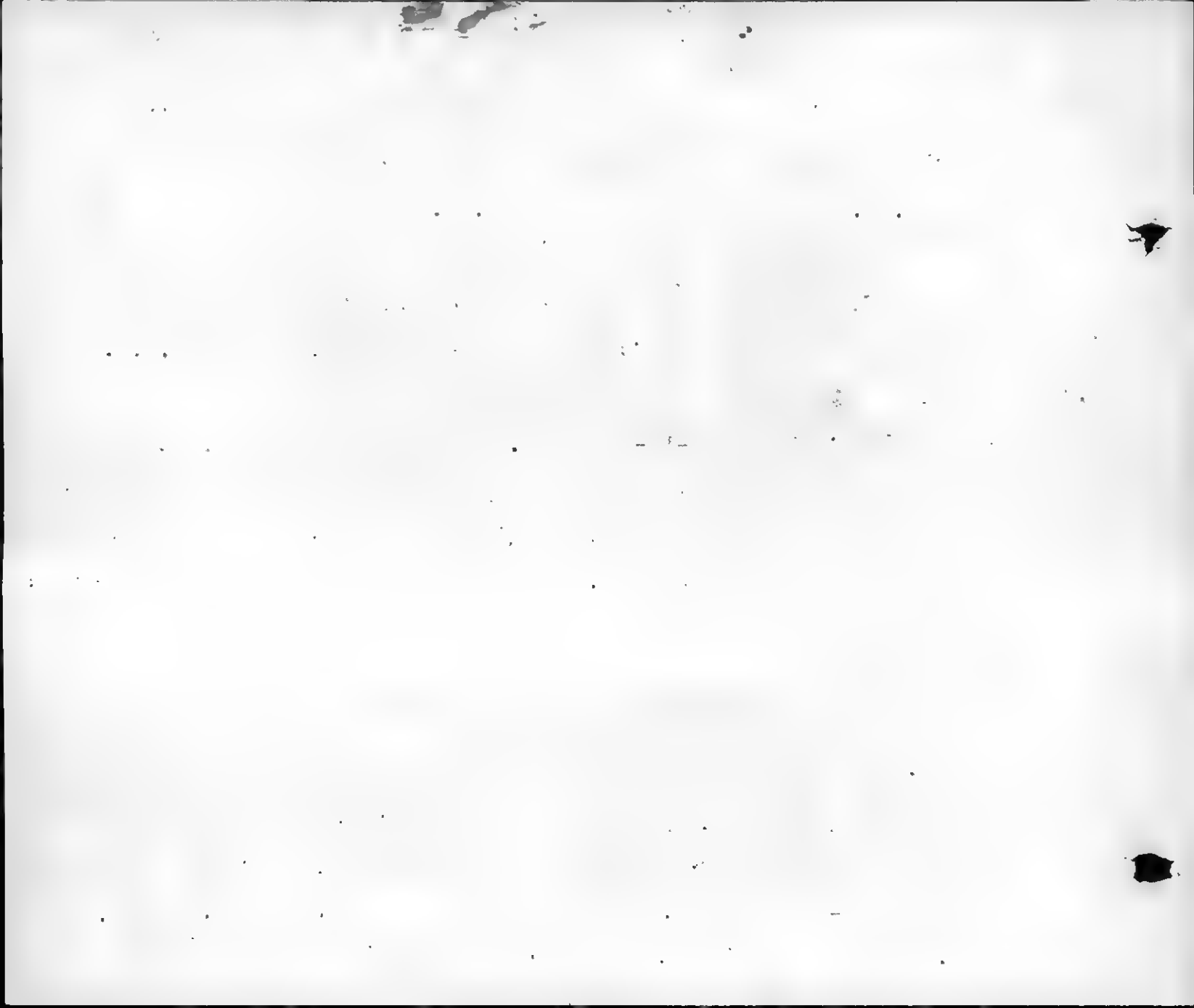


4437

## CERTIFICATE OF DEATH

64388  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Taneytown</b>		c. LENGTH OF STAY IN 1b <b>7 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. D. # 1</b>		e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LINDSAY</b> Middle <b>E.</b> Last <b>STUNKLE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 17, 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Stunkle</b>		14. MOTHER'S MAIDEN NAME <b>Estelle Larman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) *****		16. SOCIAL SECURITY NO. <b>217-10-0851</b>	
17. INFORMANT <b>Mrs. Edna Shipley Stunkle, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.1 DUE TO Condit ons, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Coronary Artery Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>2 hrs</b> <b>unknown</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>April 20</b> , 19 <b>60</b> , and that death occurred at <b>4 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. Ambler Thompson</b> M.D.		ADDRESS (Street, city or town, state) <b>Taneytown, Md.</b> DATE SIGNED <b>4/20/60</b>	
PHYSICIAN'S NAME (Type) <b>E. Ambler Thompson</b>		<b>Taneytown Md.</b> <b>4/20/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-23-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.M. WALTZ,</b>		ADDRESS <b>Winfield, Maryland</b>	
24a. REC'D BY REGISTRAR <b>APR 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

64389

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived IF institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>---</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>48yrs. 11mos. 13das.</b> <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>H</b> Last <b>TIERNEY</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 60</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 6, 1896</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b>		11. IF UNDER 24 HRS Hours <b>---</b> Min. <b>---</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
13. FATHER'S NAME <b>Thomas Tierney</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Zell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT <b>Records of Springfield State Hospt., Sykesville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary infarct</b> <b>4/11/60</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac hypertrophy and dilatation</b> DUE TO (c) <b>---</b>				INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy with mental deficiency</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>---</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m. --- p. m. ---</b> 19 <b>---</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b>				20g. (County) <b>---</b>			
20h. (State) <b>---</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 23</b> <b>19 60</b> to <b>Apr. 5</b> <b>19 60</b> , that (I) (we) last saw the deceased alive on <b>Apr. 5</b> <b>19 60</b> , and that death occurred at <b>2:25</b> <b>A. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Ellis S. Margolin</i>				22b. DATE <b>4/5/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Ellis S. Margolin</b>	
22d. ADDRESS <b>Sykesville, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
23d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>				23e. (State) <b>---</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC.</b>				25a. REC'D BY REGISTRAR <b>APR 6 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
ADDRESS <b>715 Light St.</b>							
<b>Baltimore-30, Md.</b>							





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, MD									
4439 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 20 Film 261 4-18-60 et									
Item 14 Film 261 4-18-60 et									
Reg. Dist. No. 44390									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>20y 8m 23d</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		V 1.4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George</b>			First Middle Last <b>Trower</b>			4. DATE OF DEATH Month Day Year <b>4 - 2 - 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-25-24</b>		9. AGE (In years last birthday) <b>35</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>35</b>	
13. FATHER'S NAME <b>William Trower</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Obstruction of nose and mouth from mud in river</b> DUE TO (a), stating the underlying cause last. (c) <b>minutes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with Convulsive Disorder. Clouded state.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found by creek side dead. Was an epileptic. Man had not been seen for several days.</b>							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4/2/60</b>	
EXAMINER'S NAME (Type) <b>JAMES T MARSH</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>H-6-66</b>		22b. DATE THEREOF <b>4-6-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Springfield Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Harris</b>				ADDRESS <b>Springfield Hospital</b>		24a. REC'D BY REGISTRAR DATE <b>APR 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Harris</b>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

4440  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

64391

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>			
c. LENGTH OF STAY IN 1b <b>7 days</b>				d. STREET ADDRESS <b>11804 Georgia Ave.</b> <b>3320 x Pendleton Drive</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Alice A. Ulinski</b>				4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1882</b>	9. AGE (In years last birthday) <b>77</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home -</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Myocardial infarction</b> DUE TO (c) <b>Pernicious anemia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Days</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychosis.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 5, 1960</b> to <b>April 12, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 11, 1960</b> , and that death occurred at <b>1:25 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Edmund Lusthaus</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE <b>4/12/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>TRA.S. &amp; BURIAL</b>		23b. DATE THEREOF <b>4/16/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>POLISH CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>NATRONA HEIGHTS, PENNSYLVANIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>APR 18 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>			

MEDICAL CERTIFICATION

290.8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1 4  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
64392  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>2 yrs., 6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Hawthorne</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City 311</b> d. STREET ADDRESS <b>Route # 1, Box 137 B</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Dennison</b> Last <b>Wadsworth</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5-1884</b>
9. AGE (In years last birthday) <b>75</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WPA Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Wadsworth</b>		14. MOTHER'S MAIDEN NAME <b>Percilla Dennison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>211-07-1120.</b>	
17. INFORMANT <b>Hospital records</b>		Address <b>Sykesville, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome asso. with cerebral arteriosclerosis. Bilateral Hydro-nephrosis.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>4-4-</b> 19 <b>58</b> , to <b>4-10-</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>4-10-</b> 19 <b>60</b> , and that death occurred at <b>4-10-</b> M, from the causes and on the date stated above			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>4-10-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b>		22d. ADDRESS <b>Sykesville, Maryland.</b>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>South Fork Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>South Fork, Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Sander &amp; Sons, Inc.</b>		25a. REC'D BY REGISTRAR <b>APR 12 '60</b>	
ADDRESS <b>Baltimore, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	

43200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4, may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

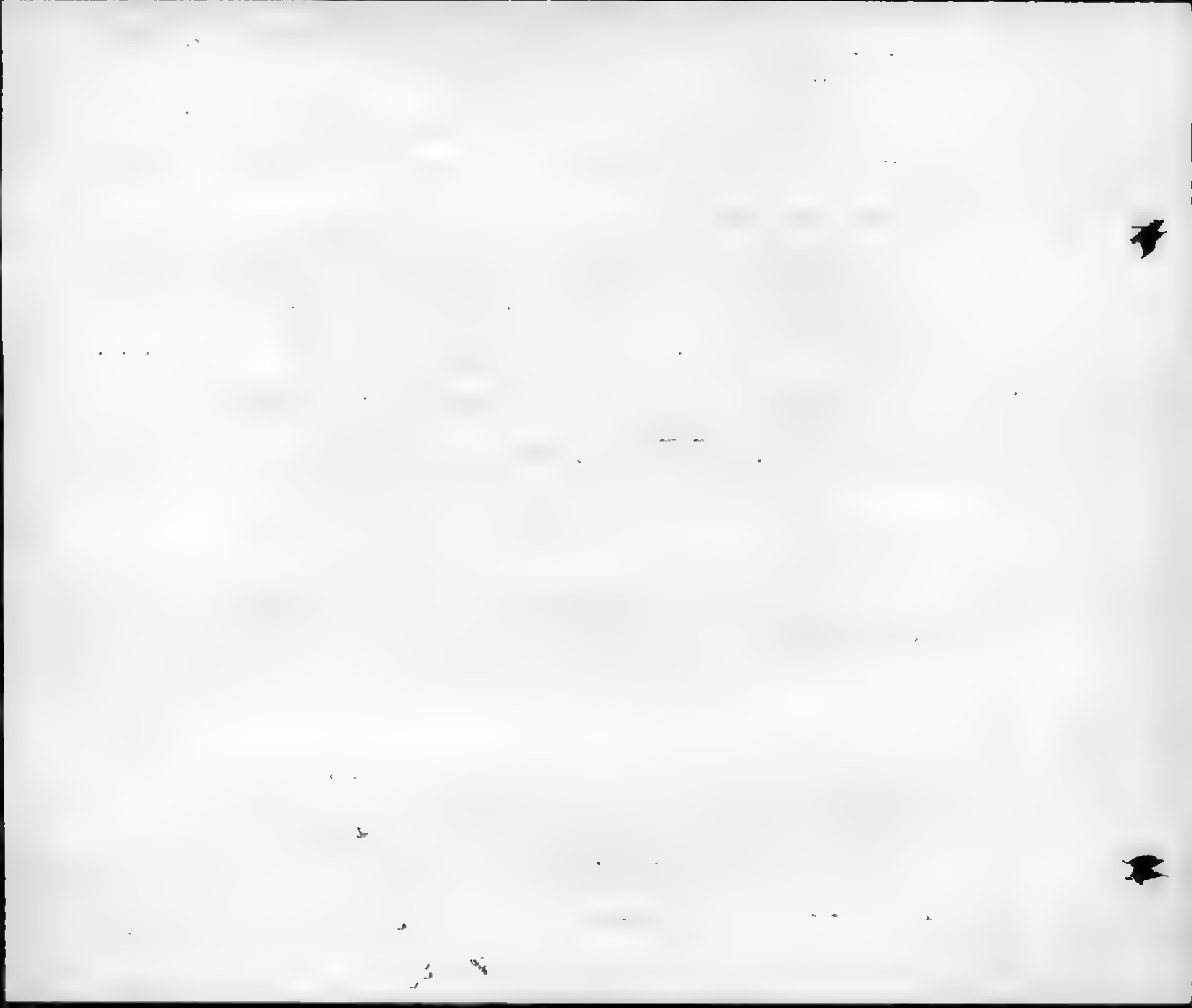
4442

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64393

1. PLACE OF DEATH a. COUNTY <b>Cornell</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seesville</b> c. LENGTH OF STAY IN 1b <b>15 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route #3 Ellicott City, Maryland</b> d. STREET ADDRESS <b>-</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Agnes Gertrude Rinehart Warfield</b>				4. DATE OF DEATH Month Day Year <b>April 28 1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 5, 1896</b>	
9. AGE (In years lost birthday) <b>63</b> yrs.		10. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jesse Penn Rinehart</b>				14. MOTHER'S MAIDEN NAME <b>Emma Clara Brengle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213-09-6092</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>71X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with pre-genile disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-13-60</b> to <b>4/23/60</b> , 19____, that (I) (we) last saw the deceased alive on <b>4/22/60</b> , 19____, and that death occurred <b>12:50 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/23/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-1-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Linthicum Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Clarksville, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. E. ...</b>				25. REC'D BY REGISTRAR DATE <b>MAY 3 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

MEDICAL CERTIFICATION





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> c. LENGTH OF STAY IN 1b <u>25 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>✓</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hampstead</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>WILLIAM-BERNARD-WHITE</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>9</u> Year <u>1960</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 27-1911</u>	
<b>9. AGE</b> (In years last birthday) <u>48</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months _____ Days _____		<b>11. IF UNDER 24 HRS.</b> Hours _____ Min. _____		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Motor Exp Co</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>	
<b>13. FATHER'S NAME</b> <u>Bernard B White</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Grace Alexander</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>215-07-4835</u>		<b>17. INFORMANT</b> <u>Mrs W B White-Hampstead Md</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ a. m. _____ p. m. Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>James J Marsh</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>4/9/60</u>	
<b>EXAMINER'S NAME (Type)</b> <u>JAMES J MARSH</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Apr 12-1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenmount</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Carroll Co Md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edw A Lepton</u>				<b>ADDRESS</b> <u>Hampstead Md</u>		<b>24a. REC'D BY REGISTRAR</b> <u>APR 13 '60</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kneave</u>				<b>24c. REGISTRAR'S SIGNATURE</b> _____			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

420.1

# MARYLAND STATE DEPARTMENT OF HEALTH

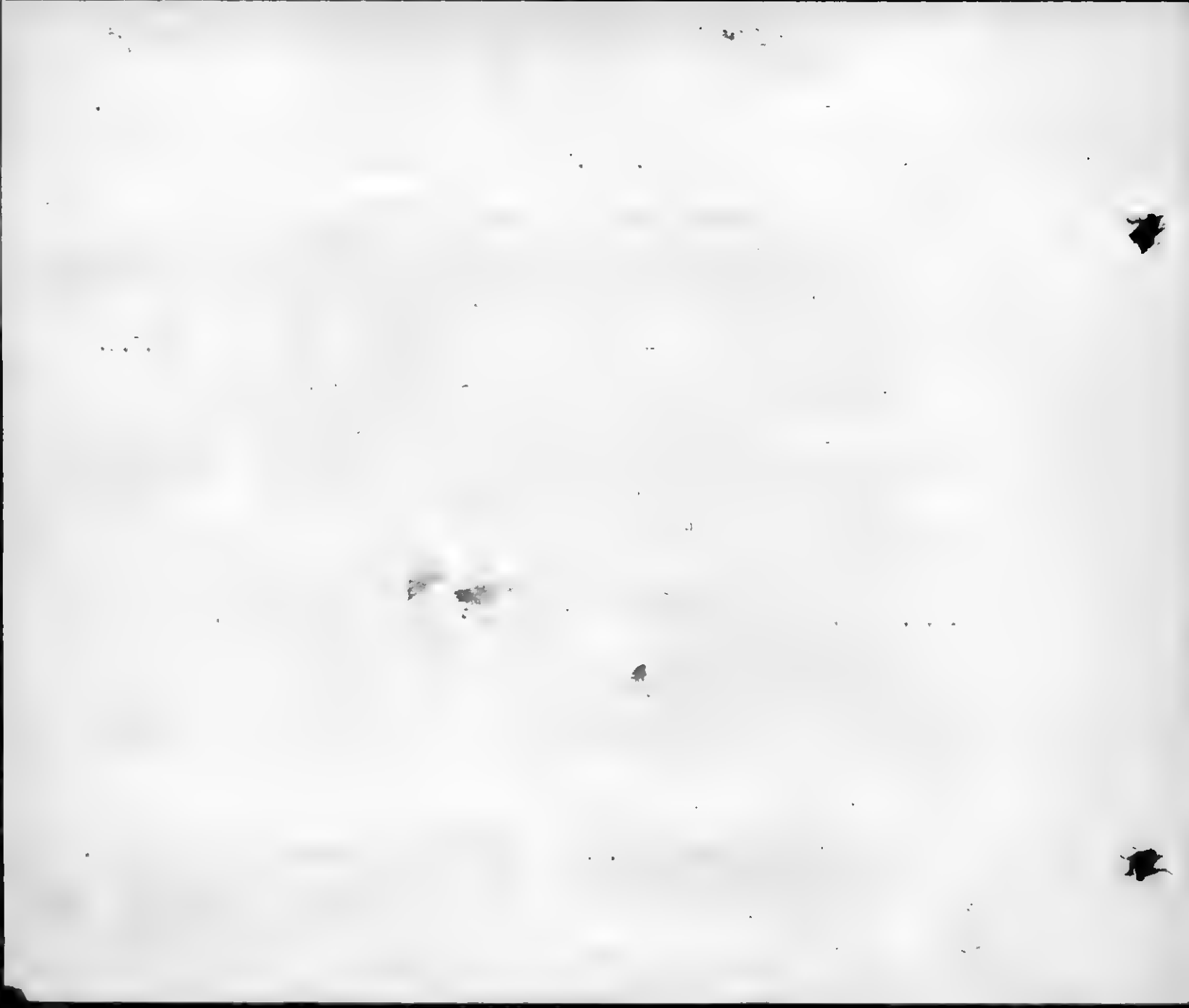
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

64395

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Carroll</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> <span style="float: right;">b. COUNTY <span style="font-size: 1.2em;">Montgomery</span></span>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Sykesville</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">3yrs. 2mos. 23days</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Silver Spring</span> <span style="float: right;">1512-2</span>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="font-size: 1.2em;">Springfield State Hospital</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">317 Southwest Drive</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <span style="font-size: 1.2em;">Pearl Lena Gordon Whitwell</span>				<b>4. DATE OF DEATH</b> <span style="float: right;">Month Day Year</span> <span style="font-size: 1.2em;">April 21, 1960</span>				
5. SEX <span style="font-size: 1.2em;">Female</span>		6. COLOR OR RACE <span style="font-size: 1.2em;">White</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">Sept. 20, 1893</span>		
9. AGE (In years last birthday) <span style="font-size: 1.2em;">66 yrs</span>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		
10b. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">-</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Arkansas</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>				
13. FATHER'S NAME <span style="font-size: 1.2em;">Frederick Gordon</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Julia Belle Gibbs</span>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">-</span>		17. INFORMANT Address <span style="font-size: 1.2em;">Springfield Hospital Records</span>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Bilateral Bronchopneumonia</span> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="font-size: 1.2em;">491X</span> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Days</span>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="font-size: 1.2em;">C.B.S. assoc. with presenile brain disease with psychotic reaction.</span>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <span style="float: right;">19</span>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1/28/1957</span> to <span style="font-size: 1.2em;">4/21/60</span> 19____ that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">April 20, 1960</span> , and that death occurred at <span style="font-size: 1.2em;">2:00AM</span> from the causes and on the date stated above.								
22a. SIGNATURE <span style="font-size: 1.2em;">Julian Radcykowycz, M.D.</span>				22b. ADDRESS <span style="font-size: 1.2em;">Springfield Hospital, Sykesville, Md.</span>				
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Cremation</span>		23b. DATE THEREOF <span style="font-size: 1.2em;">Apr. 22, 1960</span>		23c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">P. LINCOLN CREMATORY</span>		23d. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">DANEBURG MICHIGAN</span>		
24. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.2em;">[Signature]</span>				ADDRESS <span style="font-size: 1.2em;">254 Carroll St. N.W.</span>		25. REC'D BY REGISTRAR <span style="font-size: 1.2em;">[Signature]</span>		
26. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">[Signature]</span>				DATE <span style="font-size: 1.2em;">Apr 25 '60</span>				

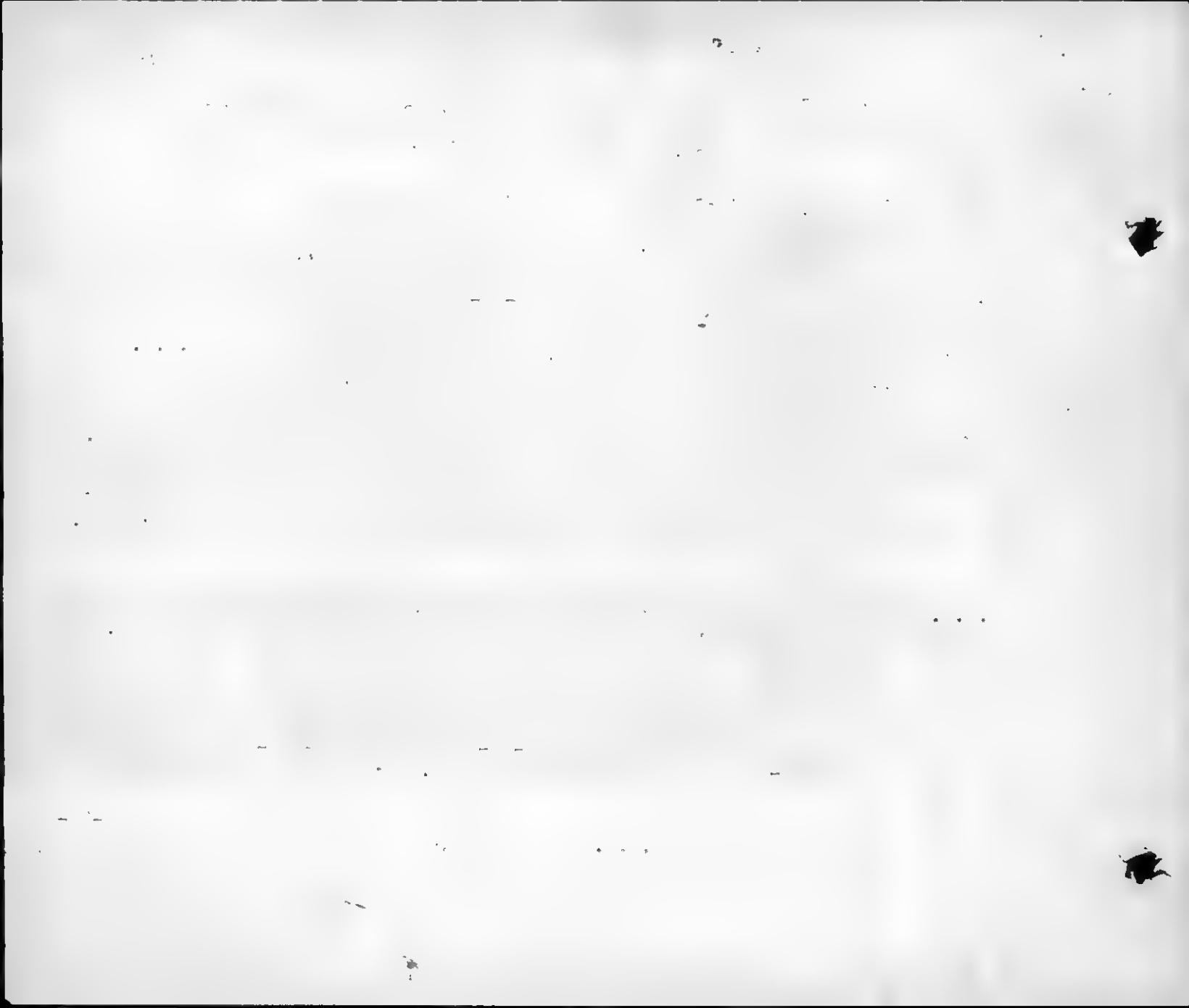
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

## 64396

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b> <b>30</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10moths25days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3006 Ailsa Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Mary</b> Middle <b>Jane</b> Last <b>Wilcox</b>		4. DATE OF DEATH Month <b>4</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-22-1892</b>	9. AGE (In years last birthday) yrs. <b>68</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>23</b> Hours <b>19</b> Min <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Theater Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cameo Theatre</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Adam Hardt</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Grossman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Hospital records Sykesville, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis (Abdominal)</b> DUE TO <b>Due to Carcinoma of the Cecum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>C.B.S. associated with circulatory disturbances cerebral arteriosclerosis with psychotic reaction.</b> (c) <b>C.B.S. associated with circulatory disturbances cerebral arteriosclerosis with psychotic reaction.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>months.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with circulatory disturbances cerebral arteriosclerosis with psychotic reaction.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-28-1959</b> to <b>4-23-1960</b> , that (I) (we) last saw the deceased alive on <b>4-23-1960</b> , and that death occurred at <b>9:20 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Agustin del Campo</b>		M. D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4-24-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-27-60</b>		23b. DATE THEREOF <b>4-27-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>	
23d. LOCATION (City, town, or county) <b>BALTO Md</b>		23e. LOCATION (State) <b>Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Luck</b>		ADDRESS <b>5305 Harford Rd</b>		25a. REC'D BY REGISTRAR DATE <b>APR 27 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>					



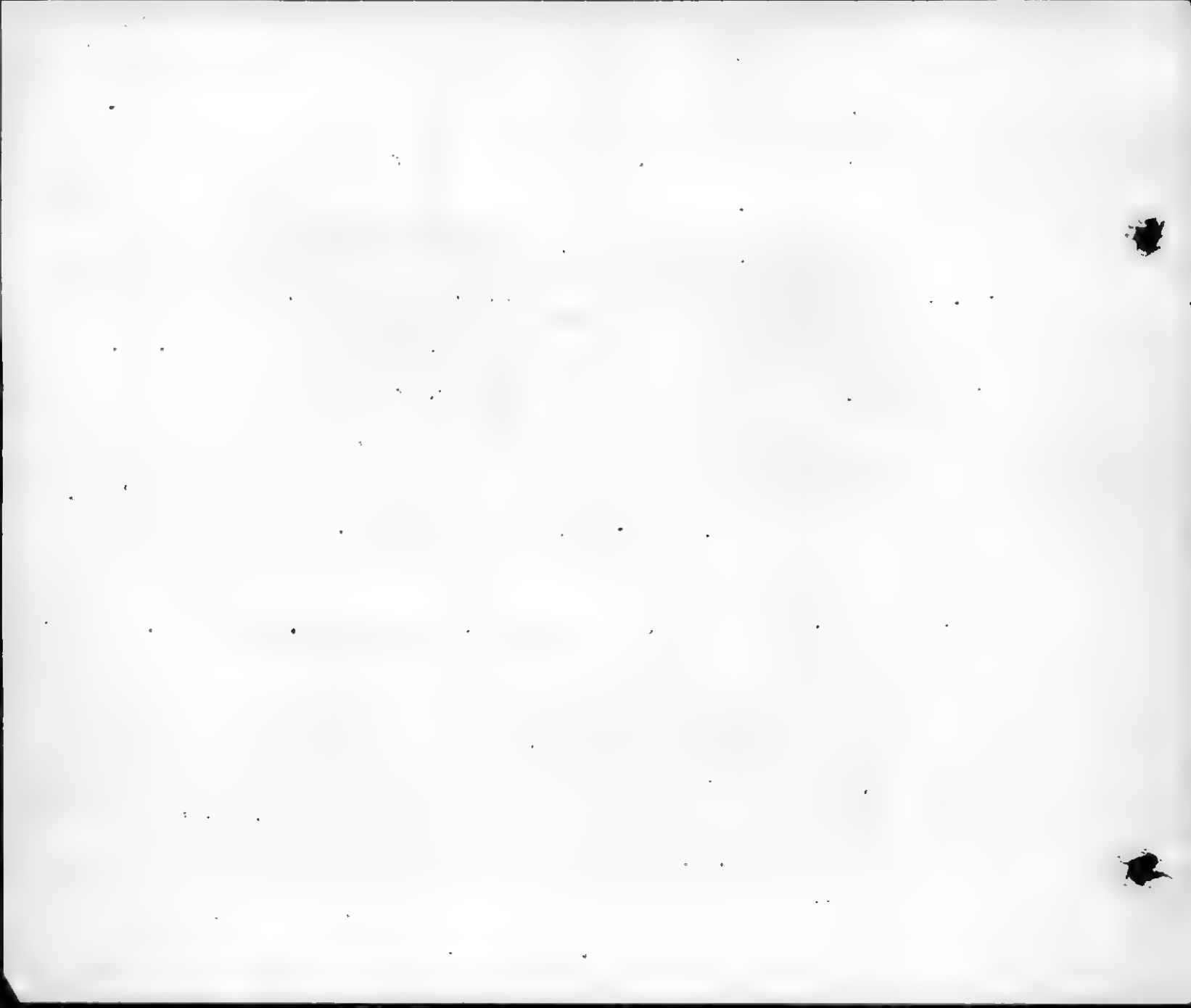
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4446

## CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN lb <b>5 mos. 6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Catherine</b> Last <b>WILLARD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1-1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Cubitt</b>		14. MOTHER'S MAIDEN NAME <b>Christine Monred</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Hospital records.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) <b>Chronic brain syndrome assoc. with senile brain dis., with psych. react.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome assoc. with senile brain dis., with psych. react.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 28, 1959</b> to <b>April 4, 1960</b> , that I last saw the deceased alive on <b>April 4, 1960</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Else Kamm, M.D.</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Else Kamm, M. D.</b>		DATE SIGNED <b>4-5-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>		24a. REC'D BY REGISTRAR <b>APR 8 '60</b>	
ADDRESS <b>Barnesville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kamm</b>	





4447

## CERTIFICATE OF DEATH

64398

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arcadia Rural</u>		c. LENGTH OF STAY IN lb <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fringer Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carroll D. J. Wisner Sr.</u>		4. DATE OF DEATH Month Day Year <u>April 22 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1889</u>
9. AGE (In years, last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter J. Wisner</u>		14. MOTHER'S M maiden name <u>Sophia M Beckley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-36-7936</u>	
17. INFORMANT <u>Elvie P. Wisner</u>		Address <u>Upperco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO (b) <u>Arterio-Sclerotic Cardio-Vascular Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease -</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March 12, 1955</u> to <u>April 22, 1960</u> , that I last saw the deceased alive on <u>April 19, 1960</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Maryland</u> DATE SIGNED <u>4/22/60</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		<u>HAMPSTEAD MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 25-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cleveland C. Tipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>APR 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4443

## CERTIFICATE OF DEATH

64399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster All Holy</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>89 Liberty Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY MILLARD ZEPP</u>				4. DATE OF DEATH <u>April 3 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 19 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Millard Zepp Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Betty Myerby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>613-09-8274</u>			
17. INFORMANT <u>Mrs. H. M. Zepp Westminster Md</u>				Address <u>89 Liberty St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis with</u> <u>443X</u> DUE TO <u>Valvular disease &amp; Heart block</u> Caudilians, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis &amp;</u> DUE TO <u>Hypertension</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>34.20</u> <u>5/1000</u> <u>uncl</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>December 1956</u> to <u>April 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 3</u> , 19 <u>60</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster Md</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>4/4/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rivers Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rural Westminster Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myerby</u> ADDRESS <u>Westminster Md</u>				24a. REC'D BY REGISTRAR <u>APR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

<p>NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>AGE</p> <p><i>45</i></p>	
<p>SEX</p> <p><i>Male</i></p>		<p>RACE</p> <p><i>White</i></p>	
<p>DATE OF BIRTH</p> <p><i>Jan 15 1878</i></p>		<p>PLACE OF BIRTH</p> <p><i>St. Louis, Mo.</i></p>	
<p>DATE OF DEATH</p> <p><i>Dec 10 1923</i></p>		<p>PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE</p> <p><i>Myocardial Infarction</i></p>	
<p>PERMANENT CAUSE</p> <p><i>Arteriosclerosis</i></p>		<p>INTERESTING FACTS</p> <p><i>None</i></p>	
<p>SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>DATE OF SIGNATURE</p> <p><i>Dec 10 1923</i></p>		<p>DATE OF SIGNATURE</p> <p><i>Dec 10 1923</i></p>	